

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 114495-001

v

Priority Health
Respondent

**Issued and entered
this 28th day of April 2011
by R. Kevin Clinton
Commissioner**

ORDER

**I
BACKGROUND**

On July 29, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation (OFIR) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On August 18, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Petitioner is a member of Priority Health, a health maintenance organization. The Priority Health certificate of coverage and related schedule of copayments and deductibles define her benefits. Priority Health was notified of the request for external review and on August 24, 2010, furnished the information used in making its final adverse determination.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

Petitioner is a 28 year-old female who has been experiencing varying degrees of abdominal pain during the past four years. She has seen several participating gastroenterologists, but has not been satisfied with their diagnoses. Petitioner scheduled an appointment for July 15, 2010 to see Dr. XXXXX, a non-participating gastroenterologist at the University XXXXX in XXXXX.

On June 21, 2010, Petitioner's primary care physician requested authorization from Priority Health for Petitioner to see Dr. XXXXX. Priority Health denied the request. On July 15 and July 19, 2010, Petitioner was evaluated and treated by Dr. XXXXX. Priority Health denied coverage because the services provided by Dr. XXXXX are available within the Priority Health network of providers.

The Petitioner appealed the denial through Priority Health's internal grievance process. Priority Health affirmed its decision in a final adverse determination letter dated August 4, 2010.

III ISSUE

Did Priority Health properly deny the Petitioner coverage for services from non-participating providers under the terms of the certificate?

IV ANALYSIS

Petitioner's Argument

In her July 29, 2010, letter of appeal to OFIR, Petitioner wrote:

I currently have been having these gastro issues for four years now. I have . . . had countless visits to the ER. I have these what I call flare ups of epigastric and right sided abdominal pain which used to only last about a week or so and then I would recover. Starting May 14, 2010 I started having the worst flare up I have had so far. I could barely walk I had excruciating . . . pain and lumbar back pain, and have still yet to recover from this current flare up. I was sent directly to the ER from my [doctor's] office during this flare up and the ER via CT scan found swollen abdominal lymph nodes. However, not one doctor I have seen so far has been able to pin point the problem that is why my [doctor] was willing to

refer me to XXXXX for care, because, they have one of the largest most specialized gastro units in the US and it is closer to my home.

. . . I feel the need for a second opinion from a doctor of my choice which is Dr. XXXXX of XXXXX however, Priority Health refuses to cover it because it is not in network and they feel I have not exhausted all options.

I told the insurance company that may be true that I have not seen very many specialists but, the reason for that is because I am a single mother who has to work, so I have been resorting to the ER on most occurrences to avoid taking time off work.

Petitioner contends that she should be able to see the doctor of her choice regardless of their network status when seeking a second opinion, when she has already had a first opinion with a participating provider.

Respondent's Argument

In its August 25, 2010, position paper addressed to OFIR, Priority Health wrote:

Priority Health determined that the requested services are excluded from coverage as medically appropriate treatment for [Petitioner's] condition was and is available within the Priority Health network of providers. As a result, Priority Health denied retroactive coverage for an office consultation, testing and treatment provided on July 15 and 19, 2010 as well as coverage for future services to be provided by the University XXXXX, a non-participating provider.

Priority Health argues that Petitioner proceeded with treatment with a non-participating provider with the knowledge that the services would not be covered as in-network resources are available. Priority Health maintains its denial was appropriate.

Commissioner's Review

The Priority Health certificate of coverage requires members to obtain services from participating providers whenever possible and to obtain prior approval for services from nonparticipating providers, except for urgent or emergent situation:

Section 2. Obtaining Covered Services

* * *

C. Referrals.

Services with a Non-Participating Provider are covered when the standard of care treatment (medically appropriate treatment) for your condition is not available from a Participating Provider. All referrals to or services received from Non-Participating Providers (providers not listed in our provider directory) must be prior approved by us. If you do not receive written approval from Priority Health prior to obtaining services from a Non-Participating Provider, you will be responsible for payment.

NOTE: Sometimes your PCP or other Participating Physician may refer you for or suggest a service that we do not Cover. Just because your PCP or other Participating Physician refers you or suggests the service does not mean you will have Coverage for that service. Remember – If you receive services that we do not Cover, you must pay for those services.

A Second Medical Opinion

A second medical opinion from a specialist may be appropriate for certain health conditions and proposed surgeries. Requests for second opinions must be initiated by your PCP (not a Specialist Provider). We will Cover second medical opinions requested by your PCP from Participating Providers having skills and training substantially similar to those of the Physician making the original treatment recommendation. If no Participating Provider is available and your PCP documents the need for a second opinion, we may Cover a second medical opinion from a Non-Participating Provider if approved by us before the second opinion is obtained. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Participating Provider unless we approve the services in advance.

Section 6. Covered And Non-Covered Services states in part:

Services Not-Covered

(d) Unauthorized Services and Supplies.

- (i) Services and supplies that were provided without any required advance approval by us

* * *

- (g) Non-Participating Providers. Non-Participating Providers are those not listed in our provider directory. For the most complete directory, call our Customer Service Department or visit our member center on our website at priorityhealth.com. Services and supplies received from Non-Participating Providers are not Covered, except in the case of a Medical Emergency or if approved by us in writing prior to obtaining the services and supplies. . . .

A fundamental premise of an HMO is the centralization of health care delivery within its network of providers. If an HMO member uses a non-participating provider when services from participating providers are available, payment for the non-participating provider services may be

greatly reduced or even excluded entirely by the HMO. These requirements are consistent with managed care contracts.

In Petitioner's case, she did have a referral from her PCP but it was not authorized by Priority Health prior to beginning treatment with Dr. XXXXX. Furthermore, there is nothing in the record that documents she met any of the exceptions to the prior authorization requirement.

The Commissioner finds that Priority Health's denial of coverage was consistent with the terms and conditions of the certificate.

**V
ORDER**

The Commissioner upholds Priority Health's August 4, 2010, final adverse determination. Priority Health is not required to provide coverage for the services Petitioner received from a non-participating provider on July 15 and July 19, 2010, nor is it required to approve future treatment from non-participating providers.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner