

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. 116657-001

v

Priority Health
Respondent

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

ORDER

**I
BACKGROUND**

On August 26, 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 September 2, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Priority Health was notified of the request for external review and on August 31, 2010, and September 8, 2010, furnished the information it 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

The Petitioner is a member of Priority Health, a health maintenance organization (HMO). His health care benefits are defined in the Certificate of Coverage (the certificate).

On October 20, 2003, the Petitioner underwent a lumbar discectomy. Despite this surgery he began to experience leg and back pain. On June 28, 2010, he requested authorization and coverage for a consultation and treatment from XXXXX, MD, at the Institute for XXXXX in XXXXX, California (the Institute). Neither Dr. XXXXX nor the Institute is part of Priority Health's network of providers.

Priority Health denied the request on the basis that treatment was available within its network. The Petitioner appealed the denial through Priority Health's internal grievance process. Priority Health affirmed its decision in a final adverse determination dated August 19, 2010.

III ISSUE

Did Priority Health properly deny the Petitioner coverage for out-of-network services under the terms of the certificate?

IV ANALYSIS

Petitioner's Argument

In December 2004 the Petitioner received injections from Dr. XXXXX to eliminate his leg pain and back pain. He was able to live a relatively normal life free from pain until 2010. Then he began to experience leg and back pain again and wants to receive another round of injections from Dr. XXXXX.

The Petitioner makes these arguments for seeing Dr. XXXXX:

- Dr. XXXXX uses an MRI to guide the precise placement of injections; no comparable treatment is available in Priority Health's network.

- Since his surgery, he has not been able to find adequate care in Michigan.
- Dr. XXXXX's treatment saved medical expenses related to his spine for six years.
- He has confidence and faith in Dr. XXXXX to treat his delicate spinal area; Dr. XXXXX is able to treat him in the least invasive way with success.

The Petitioner wants Priority Health to cover the requested consultation and treatment from Dr. XXXXX.

Respondent's Argument

In its final adverse determination dated August 19, 2010, Priority Health denied coverage stating in part:

Service for [the Petitioner's] condition is available in plan. Service with non-participating providers is not a covered benefit when medically appropriate treatment is available within the Priority Health Network of Providers in accordance with the Certificate of Coverage. The accepted standard of care is available in plan.

Priority Health based its denial on provisions of its certificate (p. 4):

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.

Priority Health argues its denial was appropriate because in-network resources are available.

Commissioner's Review

Under the terms of the certificate, Priority Health covers services from non-participating providers only when “the standard of care treatment (medically appropriate treatment)” is not available from a participating provider; and the services have been approved in advance by Priority Health.

These requirements are consistent with managed care contracts. Priority Health, as an HMO, operates within a network of providers, called participating (or affiliated) providers, who sign contracts and agree to accept Priority Health's negotiated rates. 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.

Moreover, HMOs are required to have sufficient numbers and types of providers to ensure that that covered services are available without delay. See MCL 500.3530. If an HMO does not have a sufficient number or type of participating providers, it must see that an enrollee obtains the covered benefit from a non-participating provider at no greater cost to the enrollee than if the benefit were obtained from a participating provider.

The record does not establish that Priority Health's network does not have sufficient orthopedic or neurosurgery specialists. Priority Health furnished the names of numerous participating specialists. The Commissioner understands that the Petitioner felt his treatment with Dr. XXXXX was successful and would like to treat with him again. However, Priority Health has available providers to perform medically appropriate care. It has also not been shown that the Petitioner was evaluated by a Priority Spine Center of Excellence which is a requirement in Priority Health's “Spine Centers of Excellence” medical policy before a referral is made to orthopedic or neurosurgeons.

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

**V
ORDER**

The Commissioner upholds Priority Health's August 19, 2010, final adverse determination. Priority Health is not required to provide coverage for the requested services from a non-participating provider.

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