

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

v

File No. 120123-001

Priority Health

Respondent

Issued and entered
this 20th day of June, 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 18, 2011, 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 March 25, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

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 has a history of major depressive disorder. In June 2010, she had a vagus nerve stimulator (VNS) implanted to aid in the treatment of her depression. The device is battery-powered and is placed in the upper left chest and connected to the vagus nerve.

Petitioner says she has had trouble with the device and none of the network providers she has seen has been able to find out what is wrong. She requested prior authorization to see an out-

of-network provider who specializes in VNS. Priority Health denied the request on the basis that the requested services 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 February 4, 2011.

III. ISSUE

Did Priority Health properly deny the Petitioner's request to receive treatment from a non-participating provider under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

Petitioner says her health has been declining ever since the nerve stimulator was implanted on June 3, 2010. She says she feels as if her body is shutting down. She says that none of the Priority Health participating providers have been able to assist with her medical problems. She now feels that it may have been a mistake to have the device installed because she had several pre-existing medical conditions that should have prevented her from having the VNS installed: pulmonary hypertension, a closed head injury and sleep apnea.

Petitioner says she contacted the manufacturer of the VNS device and was told that Dr. XXXXX of XXXXX, Illinois has a lot of experience with the VNS device and could assist with her medical problems. Petitioner argues that, since no one is available in network to treat her condition, Priority Health should provide authorization for her to consult with Dr. XXXXX.

Respondent's Argument

In its February 4, 2011 final adverse determination, Priority Health denied coverage stating:

Service for [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 agrees that, in addition to the VNS, Petitioner has numerous other health conditions (pulmonary hypertension, diabetes mellitus, peripheral neuropathy, and sleep apnea) that need to be explored as possible sources for the symptoms she is experiencing. Priority

Health says it has provided Petitioner with the names of additional in-network neurologists who could treat her.

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 emergency situations:

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. Referral by your PCP is not sufficient for Coverage of services received from Non-Participating Providers. 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.

These requirements are consistent with managed care contracts. As a health maintenance organization, Priority Health operates within a network of providers, called participating providers, who agree to accept Priority Health's negotiated rates. 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.

As a result, the Commissioner finds that the record does not establish that treatment is unavailable within Priority Health's network of participating providers. The Commissioner finds Priority Health's denial of coverage was consistent with the terms and conditions of the certificate of coverage.

V. ORDER

The Commissioner upholds Priority Health's February 4, 2011, final adverse determination. Priority Health is not required to provide coverage for the medical services Petitioner is seeking 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 60 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