

**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. 118095-001

v

Priority Health HMO  
Respondent

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**Issued and entered  
this 23<sup>rd</sup> day of June 2011  
by R. Kevin Clinton  
Commissioner**

**ORDER**

**I. BACKGROUND**

On November 15, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner immediately notified Priority Health of the external review and requested the information it used in making its adverse determination. The Commissioner received Priority Health's initial response on November 17, 2010.

On November 22, 2010, 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**

From July 1, 2005, through June 30, 2010, the Petitioner received group health benefits through this employer under a Priority Health PPO plan. Effective July 1, 2010, his group coverage changed to Priority Health's health maintenance organization (HMO). His HMO benefits are defined in the certificate of coverage (the certificate).

The Petitioner began receiving outpatient mental health services from Dr. XXXXX in 2008. Dr. XXXXX is a participating provider with the Priority Health PPO plan but not with Priority Health HMO.

When his coverage changed in 2010, the Petitioner submitted a request to Priority Health HMO for authorization to continue receiving services from Dr. XXXXX. Priority Health HMO denied the request on the basis that mental health services are available within its network of providers.

The Petitioner appealed the denial through Priority Health's internal grievance process. Priority Health affirmed its denial in a final adverse determination dated September 15, 2010.

## **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 explained in his request for external review:

I was informed by Priority Health that Dr. XXXXX was a participating provider when I found him listed on their website. They informed me after several visits he wasn't participating. I filed grievance & appeal & they listed him as participating. Priority is not clear now as they say he is not participating as of July 1, 2010, when I won my appeal when they stated he was. Priority is not clear with their consumers on who is participating which inadvertently forces consumers to stop services.

The Petitioner is requesting Priority Health HMO to allow him to continue to receive treatment from Dr. XXXXX as though he were a participating provider.

Respondent's Argument

In its September 15, 2010, final adverse determination, Priority Health HMO gave its reasons for denying the Petitioner's request to continue therapy with Dr. XXXXX:

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.

Priority Health HMO did allow the Petitioner to see Dr. XXXXX for three visits within the first 90 days of coverage while he transitioned to a network provider.

Commissioner's Review

The certificate generally requires members to obtain services from a participating provider. Other than urgent or emergency care, service from a non-participating provider is not covered when treatment is available from a participating provider. This requirement is commonly found in HMO contracts. The certificate states:

**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. . . .  
[Underlining in original]

Priority Health 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 that network. 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.

Understandably, the Petitioner wishes to continue to receive services from a therapist with whom he has had a long-standing relationship. However, Priority Health HMO has identified numerous providers within its network that can provide mental health services and there is nothing in the record from which the Commissioner could conclude that in-network treatment is not available for the Petitioner. Moreover, the Petitioner has not asserted that services are not available from a network provider - - he only wants Priority Health HMO to cover his on-going treatment with his non-network provider, Dr. XXXXX.

In the notes of from the grievance committee, the Petitioner suggests that Dr. XXXXX was specifically excluded as a provider by Priority Health HMO or was prevented from joining its network. Priority Health HMO explained that it uses a different network for behavioral health services than the Priority Health PPO plan and that Dr. XXXXX only participates with the PPO plan. In any event, Dr. XXXXX's participation status cannot be taken up in an external review under the Patient's Right to Independent Review Act.

The Commissioner finds Priority Health's denial of coverage was consistent with the terms and conditions of the certificate and state law.<sup>1</sup>

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<sup>1</sup> Under certain limited circumstances, HMO members are permitted to continue a course of treatment with a non-participating provider. See Section 2212b of the Insurance Code, MCL 500.2212b. However, the facts in this case do not meet the criteria of Section 2212b.

## **V. ORDER**

The Commissioner upholds Priority Health's September 15, 2010, final adverse determination. Priority Health is not required to authorize coverage for the requested care 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.

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R. Kevin Clinton  
Commissioner