

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

**In the matter of**

**XXXXXX**

**Petitioner**

**v**

**File No. 119235-001**

**Priority Health**  
**Respondent**

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

**ORDER**

**I. PROCEDURAL BACKGROUND**

On January 25, 2011 XXXXX, on behalf of his minor son 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 Petitioner receives health care benefits under a certificate of coverage issued by Priority Health. The Commissioner notified Priority Health of the external review and requested the information used in making its adverse determination. Priority Health furnished the information used in making its final adverse determination and, after a preliminary review of the material submitted, the Commissioner accepted the request for external review on February 1, 2011.

The issue in this case 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 six years old and suffers from Mitochondrial Complex 1 Deficiency, a chronic condition which has resulted in difficulties with speech processing and expression, motor skill delays and other difficulties. On July 1, 2010, Petitioner's primary care physician submitted a request for speech and occupational therapy provided at The Center for XXXXX (XXXXX) in XXXXX, Michigan. The therapy had already begun when the request was filed. The request covered the period from September 18, 2009 through December 31, 2010, as well as all future visits. XXXXX does not participate in Priority Health's network of providers. Priority Health denied the request for coverage for that reason.

During the appeals process Priority Health offered a compromise and agreed to provide coverage for the treatment provided in 2010 by XXXXX up to its maximum of 30 visits per plan year.

The Petitioner's father appealed the denial of future visits through Priority Health's internal grievance process and received its final adverse determination letter dated November 26, 2010.

## **III. ISSUE**

Did Priority Health properly deny the Petitioner coverage for speech and occupational therapy treatment from a non-participating provider?

## **IV. ANALYSIS**

### Petitioner's Argument

Based on recommendations from several physicians, Petitioner's father believes that it is in his son's best interest to continue to receive speech and occupational therapy at XXXXX. Petitioner's father also believes since the treatment is working and XXXXX is one of the few providers who specialize in treating his son's condition, that Priority Health should provide coverage for future treatment.

### Respondent's Argument

In its November 26, 2010 final adverse determination, Priority Health explained its coverage decision:

Compromise – Requested coverage from September 18, 2009 through December 31, 2010 will be provided up to 30 visits per plan year at Priority Health’s contracted rate and at the [family’s] benefit level provided by The Center for XXXXX, a Non-Participating Provider. Beginning January 1, 2011, [Petitioner] will be allowed coverage of speech and occupational therapy services up to 30 visits per plan year through a Participating Provider only. [Petitioner] must transition to an in-network provider in accordance with the Certificate of Coverage and Schedule of Copayments and Deductibles. A Priority Health Case Manager will assist in finding an appropriate Participating Provider for [Petitioner].

The Appeal Committee determined that [Petitioner’s] speech issues are not due to developmental delay, but are due to his diagnosis of Mitochondrial Complex 1, therefore, speech therapy is a covered service as outlined in Priority Health’s Medical Policy #91336-R7 for Speech Therapy which states:

\* \* \*

B. Speech therapy is not covered for any of the following:

\* \* \*

3. Treatment of delays in speech development, including developmental articulation errors, unless resulting from disease, injury or congenital anatomic defects.

Priority Health argues that its decision to deny benefit coverage for Petitioner’s visits to XXXXX beyond December 31, 2010 was appropriate given that treatment is available within the Priority Health provider network.

### Commissioner’s Review

Section 2(C) of 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:

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.

This requirement is typical in managed care contracts. Priority Health, as an HMO, operates within a network of providers, called participating 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.

The Commissioner finds that the record in this appeal lacks evidence that treatment was unavailable within Priority Health's network of participating providers. Additionally, Priority Health provided transition care for a three-month period and offered to assign a case manager to assist Petitioner's family with assistance in locating an in-network provider who can treat Petitioner's condition.

The Commissioner finds Priority Health's decision is consistent with the terms and conditions of the certificate of coverage.

#### **V. ORDER**

The Commissioner upholds Priority Health's November 26, 2010, final adverse determination. Priority Health is not required to provide coverage for treatment at The Center for XXXXX after December 31, 2010.

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