

**STATE OF MICHIGAN**  
**DEPARTMENT 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. 122683-001**

**Priority Health**

**Respondent**

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**Issued and entered**  
**this 12<sup>th</sup> day of August 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On August 3, 2011, XXXXX (Petitioner) filed a request for expedited external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* In order to receive an expedited external review under PRIRA, a physician must substantiate that the Petitioner's life or health would be seriously jeopardized or the Petitioner's ability to regain maximum function would be jeopardized if an expedited review is not granted. In this case, a physician has not documented such conditions. On August 4, 2011 after a preliminary review of the material submitted, the Commissioner accepted the request for external review on a non-expedited basis.

The Commissioner notified Priority Health of the external review and requested information used in making its adverse determination. The Commissioner received Priority Health's response on August 4 and additional information was provided on August 9, 2011.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The contract here is the Priority Health HMO Certificate of Coverage (the certificate). 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**

In February 2009, the Petitioner had surgery performed by Dr. XXXXX at the XXXXX Institute for an acoustic neuroma (intracranial tumor). She was recently discovered to have a possible recurrent acoustic neuroma that requires treatment. Her physician submitted a request for Petitioner to be treated by Dr. XXXXX, at the XXXXX (X). Both Dr. XXXXX and X do not participate in Priority Health's network of providers.

Priority Health denied the request, ruling that care is available from providers within the Priority Health network. The Petitioner appealed the denial through Priority Health's internal grievance process. Priority Health affirmed its denial in a final adverse determination dated July 7, 2011.

## **III. ISSUE**

Did Priority Health properly deny authorization for treatment with non-participating providers?

## **IV. ANALYSIS**

### Petitioner's Argument

Petitioner writes in her request for external review:

I have recurring acoustic neuroma. The participating provider is the XXXXX Institute, which is more than a one-hour drive from my home. This requires numerous trips for tests & evaluation. The acoustic neuroma is causing severe dizziness & nausea which make it impossible for me to drive that long distance. I have no family nearby to drive me. I cannot get there. My doctor referred me to Dr. XXXXX of the X. It is only 15 minutes from my house. I request approval for treatment by Dr. XXXXX.

In a letter dated June 24, 2011, Petitioner's oncologist Dr. XXXXX wrote:

[The Petitioner] has an MRI that is highly suggestive of a recurrent acoustic neuroma. Due to ongoing symptoms of nausea, & vertigo she is unable to drive to Southfield to see Dr. XXXXX. I am requesting a referral to Dr. XXXXX at the University of XXXXX, which is 45 minutes closer drive than Dr. XXXXX & the XXXXX Institute. I appreciate your rapid attention to this matter.

The Petitioner believes Priority Health should approve her treatment with a non-participating provider because it is medically necessary due to her condition.

### Respondent's Argument

In its July 7, 2011 final adverse determination Priority Health denied the request for treatment from non-participating providers 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.

[Petitioner] was provided with in-plan options. . . . The accepted standard of care is available in plan.

Priority Health reviewed the drive time and determined Petitioner currently drives approximately 19 miles one way to see her oncologist and the XXXXX Institute is approximately 32 miles from her home (less than one hours drive) one way.

### Commissioner's Review

The certificate excludes coverage for services from a non-participating provider when standard of care treatment is available from participating providers. The certificate (p. 3, 4) 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. 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. (Emphasis in original.)

Priority Health is a health maintenance organization (HMO). A fundamental premise of HMOs is the centralization of health care delivery within a network of providers who sign contracts and agree to accept negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. If an HMO member uses a non-participating provider when services from participating providers are available, payment for the non-participating services may be greatly reduced or even excluded entirely by the HMO.

Petitioner argues that she cannot physically withstand the drive to the XXXXX Institute because it is an hour away from her home one way. While the Commissioner is sympathetic to the symptoms Petitioner may incur while driving/riding long distances, the record does not establish that treatment is unavailable from participating providers. In Petitioner's case, Priority Health has documented that care for her condition is available within its network from several participating providers at the XXXXX Institute.

Therefore, 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 July 7, 2011, final adverse determination. Priority Health is not required to authorize and provide coverage for 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 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