

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████,

Petitioner,

v

File No. 153488-001

Priority Health,

Respondent.

Issued and entered
this 24th day of May 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 2, 2016, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on May 9, 2016.

The Petitioner receives group health care benefits as a member of Priority Health, (Priority) a health maintenance organization. The Director immediately notified Priority Health of the external review request and asked for the information it used to make its final adverse determination. Priority Health responded on May 10, 2016.

The issue in this external review can be decided by a contractual analysis. The Director 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's health care benefits are described in a certificate of coverage issued by Priority Health (the certificate). That coverage, through her employer, was effective on March 1, 2014.

The Petitioner has recurring bone cysts and a kidney disease called “focal segmental glomerulosclerosis” (FSGS). She was treated for those conditions at the Mayo Clinic in Minnesota for several years and that care was covered while she was a dependent on her mother’s Blue Cross Blue Shield of Michigan, health plan. However, in February 2015 the Petitioner turned 26 and after March 1, 2015, was no longer eligible for coverage as her mother’s dependent. She continued to have her own coverage with Priority Health.

The Petitioner was seen at the Mayo Clinic in May 2015 and Priority Health initially denied coverage for that care because Mayo is a nonparticipating provider. Priority Health eventually agreed to cover the May 2015 visit, surgery in September 2015, and three months of after care at Mayo. But it said the Petitioner then had to transition to network providers.

The Petitioner, wishing to continue to receive care at Mayo, appealed Priority Health’s decision through its internal grievance process. At the conclusion of that process, Priority Health maintained its denial and issued its final adverse determination dated March 10, 2016. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did Priority Health properly deny coverage for further medical services at the Mayo Clinic?

IV. ANALYSIS

Petitioner’s Argument

In a letter dated April 29, 2016, submitted with her external review request, the Petitioner wrote:

I ask you to please consider my long-standing trust and care with Mayo Clinic. It is important to me to have doctors who treat me with respect and show genuine concern that I understand my health issues. The coordinated care between both departments I receive at Mayo Clinic is important.

The Petitioner also explained her position in her grievance request to Priority Health:

I am asking Priority Health to cover my out of network care. . . . I am an active 26 year old who has many active years ahead. Having the care of [my doctor at Mayo Clinic] is important to me and I hope to resolve these issues so I can continue to live quality life. The coordination of care between [my Mayo Clinic doctors] has been beneficial and at time required quickly. I am currently enrolled

in the best insurance program my employer offers. Please consider my request for on going out of network care.

Respondent's Argument

In its final adverse determination, Priority Health explained the reasons for its denial:

Uphold denial - requested coverage will not be provided. Service is available in plan. Service with NonParticipating 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. . . .

The Appeal Committee understands [the Petitioner] wishes to continue services at Mayo Clinic due to her familiarity and established relationships with her providers there, however [the Petitioner's] HMO contract requires she seek care from Participating Providers whenever possible. The Appeal Committee did not feel an exception to this requirement was appropriate in this situation.

Director's Review

A fundamental premise of health maintenance organizations is the centralization of health care delivery within a network. Priority Health uses a network of providers; it limits the use of non-network providers as explained in the certificate (p. 8):

All Covered Services you receive from Non-Participating Providers must be Prior Approved by us. If the standard of care (medically appropriate treatment) for your condition is not available from a Participating Provider, your PCP may ask Priority Health for approval to refer you to a Non-Participating Provider. If you do not receive approval from Priority Health prior to seeking Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for payment. A referral from your PCP or another Participating Provider is not enough if you want the services to be Covered. If Priority Health approves the referral, we will notify your PCP or the Participating Provider who makes the request.

Priority Health has decided that it will not approve services from non-participating providers if those services are available from network providers, and in its final adverse determination it identified several in-network specialists.¹

There is no dispute that the Petitioner's physicians at the Mayo Clinic are nonparticipat-

¹ As a health maintenance organization, Priority Health must insure that it has an adequate network in order to provide covered benefits. See MCL 500.3530.

ing providers, or that Priority Health did not authorize continuing care at the Mayo Clinic. Therefore, the Director must uphold Priority Health's final adverse determination.

The Director finds that Priority Health's denial of coverage for medical services at the Mayo Clinic beyond the transition period was consistent with the terms and conditions of the certificate.

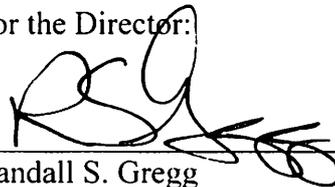
V. ORDER

The Director upholds Priority Health's May 10, 2016, final adverse determination.

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 Michigan 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director