

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. 153892-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 21st day of June 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 26, 2016, ██████████, on behalf of her minor daughter ██████████ (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.* The Director accepted the case for review on June 3, 2016.

The Petitioner receives health care benefits through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in the *MESSA Choices/Choices II* certificate of coverage.

The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. BCBSM provided its response on June 9, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner, who is three-and-a-half years old, has childhood apraxia of speech, a neurological speech disorder. She receives speech-language therapy at the Children's Therapy Corner in Midland. Her annual speech therapy benefit will run out in June 2016. Her physician and speech-language pathologist requested coverage for additional speech therapy. BCBSM

denied the request.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, on May 19, 2016, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Is BCBSM required to provide coverage for additional speech therapy for the Petitioner?

IV. ANALYSIS

BCBSM's Argument

In its March 30, 2016 final adverse determination BCBSM's representative wrote:

As a Grievance and Appeals Coordinator for [BCBSM], I have reviewed the appeal request and your family's health care plan benefits. Based on that review, I confirmed that our decision to deny additional speech therapy visits for your daughter is appropriate. Your plan only allows a maximum of 60 visits within a calendar year. Therefore, our decision to deny your request is maintained.

You family is covered through the MESSA Choices/Choices II Group Insurance for School Employees. Page 51 of the [certificate of coverage] explains that speech therapy services are covered up to a combined benefit maximum of 60 visits per member, per calendar year, whether obtained from an in-network or out-of-network provider. Additionally, all speech therapy services provided in any outpatient location (hospital-based, freestanding facility or physician's office) are combined to meet the 60 visit maximum. The benefit maximum renews each calendar year.

I appreciate your position that the additional services are medically necessary; however, when the plan has a specific visit limitation, we must adhere to it. Therefore, we are unable to approve your request.

Petitioner's Argument

In the external review request, the Petitioner's mother wrote:

My daughter has been diagnosed with severe expressive and receptive language disorder, as well as severe Apraxia of Speech. Apraxia is a neurological disorder that affects the planning and production of speech. At 3 years 8 months, my daughter is completely non-verbal. Her insurance therapy visits run out in June. We are requesting additional speech therapy visits as they are medically necessary.

In a "letter of medical necessity" dated March 1, 2016, Petitioner's physician and her

speech-language pathologist wrote:

The purpose of this letter is to outline the medical necessity for additional visits for speech-language therapy for [Petitioner], who is a 3 year 5 month old girl receiving services at this facility. [Petitioner] has a severe expressive and receptive language disorder. In addition, [Petitioner] was diagnosed with severe apraxia of speech at this facility in February 2016. Childhood apraxia of speech is a neurological speech disorder that affects speech motor planning and the ability to voluntarily regulate control over speech movement sequences. The disorder is not a developmental delay and will not resolve on its own. Apraxia of speech is not generally diagnosed until age 3 years in order to allow for appropriate differential diagnosis.

Research indicates that the challenges that [Petitioner] is demonstrating are treatable and the prognosis for improvement is much greater with intensive weekly direct intervention. [Petitioner] currently receives services at this facility two times per week for 45-minute sessions. Due to the nature and severity of her presentation of childhood apraxia of speech, the recommendation for intervention is 4 times per week. [Petitioner] has made improvements in terms of increasing vowel sounds and utilizing some simple sign language to communicate wants and needs. However, she continues to face significant challenges for producing verbalizations as she produces 2-3 words inconsistently at this time. She is currently unable to answer questions to make consistent spontaneous requests. This poses safety issues if [Petitioner] were lost, or on her own, and needing to communicate with others.

Based on research and clinical judgment, it is imperative that [Petitioner] receive direct, intensive intervention at her young age of 3 years, 5 months. It is recommended that she receive intensive treatment 4 times per week to maximize the ability to make continued improvements, which will allow her to communicate her wants and needs. Reevaluation of skills and progress will occur at 4-6 months and updated objectives and therapy plan will be determined....

Director's Review

The *MESSA Choices/Choices II* certificate of coverage, on page 51, describes the coverage provided for therapy services:

Therapy Services

The following therapy services¹ are paid as indicated below of obtained in the outpatient department of a hospital, doctor's office, freestanding facility or by an independent physical therapist. Any therapy must be medically necessary and ordered by, and performed under, the supervision or direction of a legally qualified physician except where noted.

Services are covered up to a **combined benefit maximum of 60 visits per member, per calendar year**, whether obtained from an in-network or out-of-

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1. The covered therapy services are occupational therapy, physical therapy, speech therapy, chemotherapy, radiation therapy, vision therapy, and hemodialysis.

network provider. All services provided in any outpatient location (hospital-based, freestanding facility or physician' office) are combined to meet the 60 visit maximum. This benefit maximum renews each calendar year.

The Petitioner's mother argues that additional speech therapy visits beyond the 60 visit calendar year maximum should be allowed for her daughter due to medical necessity. BCBSM does not dispute that the additional speech therapy is medically necessary. However, in this case the certificate of coverage limits therapy to 60 visits per year. The certificate offers no exception for additional therapy based on medical necessity.

In conducting contractual reviews under the Patient's Right to Independent Review Act, the Director is limited to determining whether an insurer's final adverse determination is consistent with the terms of the insured's certificate of coverage. See MCL 550.1911(13).

The Director finds that BCBSM's denial of coverage for additional speech therapy visits is consistent with the terms of the benefit plan's 60 visit annual limit, as provided in the *MESSA Choices/Choices II* certificate of coverage.

V. ORDER

The Director upholds BCBSM's final adverse determination of May 19, 2016. BCBSM is not required to provide coverage for more than the 60 therapy visits already covered.

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