

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

In the matter of:

██████████
Petitioner

v
United Healthcare Insurance Company
Respondent

File No. 146657-001

Issued and entered
this 15th day of April 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 5, 2015, ██████████, 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 Petitioner receives medical benefits under a group plan underwritten by United Healthcare Insurance Company. The family's medical benefits are defined in United Healthcare's *Choice Plus* certificate of coverage.

The Director notified United Healthcare of the external review request and asked for the information used to make its final adverse determination. After a preliminary review of the material received, the Director accepted the request on March 12, 2015. The case involves medical issues so the Director assigned the matter to an independent review organization which completed its review on March 24, 2015.

II. FACTUAL BACKGROUND

The Petitioner is a ██████ year old ██████ who has been diagnosed with apraxia of speech. From August 5, 2014 through September 19, 2014, the Petitioner received speech therapy at ██████████ Therapy Center in ██████████ Michigan.

United Healthcare denied coverage. The Petitioner's parents appealed the denial through United Healthcare's internal grievance process.

At the conclusion of the internal grievance process, United Healthcare issued a final determination letter dated January 5, 2015, affirming its denial of coverage. The Petitioner's mother now seeks a review of that determination from the Director.¹

III. ISSUE

Did United Healthcare correctly deny coverage for the Petitioner's speech therapy?

IV. ANALYSIS

Respondent's Argument

In its January 5, 2015 final adverse determination, United Healthcare cited the following provision in its *Choice Plus* certificate of coverage:

Section 2: Exclusions and Limitations

* * *

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: Covered Health Services or through a Rider to the Policy.

* * *

M. Procedures and Treatments

* * *

5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

The Choice Plus certificate defines "congenital anomaly" as "a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth."

United Healthcare stated in the final adverse determination that the Petitioner's claims were reviewed by a physician specializing in pediatrics who wrote:

1. The therapy is ongoing. However, this review concerns only the claims which were addressed in United Healthcare's internal grievance process because the Director is precluded from conducting PRIRA reviews of claim denials which have not passed through an insurer's internal grievance process. See MCL 550.1911(2).

The Plan has exclusion for Speech therapy except when the speech problem is caused by an injury, stroke, cancer, autism spectrum disorder or Congenital Anomaly. I reviewed your letter of appeal and supporting documentation. Based on the review, the denial is upheld. Based on the medical record, the speech problem is not caused by an Injury, stroke, cancer, autism spectrum disorder or Congenital Anomaly. Therefore speech therapy is not a covered benefit.

Petitioner's Argument

In a letter dated March 1, 2015, submitted with the request for an external review, the Petitioner's mother wrote:

We are requesting an external review requesting payment for speech therapy claims under the medical diagnosis of Apraxia covered as a congenital anomaly under the speech therapy guidelines as listed on the policy.

Speech therapy is a covered benefit clearly stated as "required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders". A congenital anomaly is clearly defined as "a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth."

Attached you will find [Petitioner's] medical records from her 12 month wellness check (dated 2/19/13) in which her pediatrician indicated a speech problem, these areas are highlighted.

Attached you will also find a letter indicating the medical necessity of speech therapy as well as the definition of Apraxia from [Petitioner's] current Speech-Language Pathologist at [REDACTED] Therapy Center, as well as scientific literature explaining Apraxia and speech therapy for treatment. I have also attached the [REDACTED] statements as well as the submitted claim forms.

[Petitioner] started therapy on 8/5/14, and despite submitting monthly claims to UnitedHealthcare (via Rogers Benefit), we have only received two denial letters, one for the dates of 8/5/14-9/19/14, and one for the single date of 10/21/14, which makes no sense at all. I have approximately 76 email correspondence with Rogers Benefit trying to find out the status of the last 5 months of claims (therapy is twice a week). We still have not gotten an answer on the status of these claims, and are still struggling each month to pay for this therapy that my daughter desperately needs! As you can see this process with UnitedHealthcare has been an absolute confusing nightmare and is extremely stressful as no one can give us any straight answers.

The Petitioner's mother also submitted a letter from the Petitioner's speech-language pathologist, who wrote:

[Petitioner] requires coverage for speech and language therapy.

[Petitioner] has a current diagnosis of Childhood Apraxia of Speech. This diagnosis is a congenital (present at birth) disorder of the nervous system that affects a child's ability to sequence and say sounds, syllables, and words. It is a motor disorder where the brain signals that go to the muscles and structures of the speech mechanism are disrupted. This is not a developmental disorder or a delay. Children are born with the inability to produce sounds and words. If left untreated, [Petitioner] will not develop normal or meaningful speech. This, in turn, will result directly in a deterioration of [Petitioner's] health and safety, in that she will not be able to communicate medical and personal needs as well as thrive as an otherwise typical child. With treatment, however, her prognosis is excellent.

Speech therapy is the recommended treatment for Childhood Apraxia of Speech. It is the least expensive, least invasive, and most successful form of treatment, and is accepted by the medical community. [Petitioner's] speech output is severely affected and speech therapy is necessary twice a week at a minimum in order for her to make good progress.

Director's Review

The medical issues in this case were presented to an independent review organization (IRO) for analysis as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is a physician in active practice who is certified by the American Board of Pediatrics. The reviewer submitted two reports to the Director. In the first report, submitted March 24, 2015, the reviewer concluded that the Petitioner's speech therapy was medically necessary and recommended that the denial of coverage be reversed. At the Director's request, the reviewer prepared a second report to address the provision found in the certificate of coverage — that speech therapy coverage is only available for conditions which result from injury, stroke, cancer, congenital anomaly, or autism spectrum. The second IRO report, submitted April 8, 2015, stated the following conclusion:

Based on the documentation submitted for review, the enrollee does not meet the health plan's criteria for coverage. Although the medical literature recommends speech therapy for childhood speech disorders, the enrollee's speech issues are not a result of an injury, stroke, cancer, congenital anomaly or autism spectrum disorder.

Based on this conclusion, the reviewer recommended that United Healthcare's denial of coverage be upheld. The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the

assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise, and professional judgment and the Director can discern no reason to reject the reviewer's recommendation stated in the report of March 24, 2015. The Director adopts that recommendation. That report is more specifically based on the terms of the Petitioner's coverage as described in United Healthcare's *Choice Plus* certificate of coverage than is the first IRO report. The second report addresses the exclusion in the certificate of coverage.

The Director finds that, while the Petitioner's speech therapy may be medically necessary, United Healthcare's denial of coverage is consistent with the coverage exclusion found in the certificate of coverage.

V. ORDER

The Director upholds United Healthcare's January 5, 2015, final adverse determination. United Healthcare is not required to provide coverage for the Petitioner's speech therapy.

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

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director