

ATTACHMENT A
THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Denial for
Reimbursement for Direct Voice
Rehabilitation for:

EDWARD MOORE,

Respondent.

Case No. 2011-1255

OAH No. 2014050855

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings (OAH), on February 17 and 20, 2015, in Sacramento, California.

Christopher Phillips, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Edward Moore appeared on his own behalf. He was assisted by his spouse, Raiyn Moore.

Evidence was received, the record closed, and the matter was submitted for decision on February 20, 2015.

ISSUE

Did Blue Shield of California comply with the terms of the Evidence of Coverage when it denied Edward Moore's request for coverage of Direct Voice Rehabilitation through a non-contracted provider?

FACTUAL FINDINGS

1. The Statement of Issues was made and filed on May 1, 2014, by Kathleen Donneson, Chief of the Health Plan Administration Division, in her official capacity.

PUBLIC EMPLOYEES RETIREMENT SYSTEM

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2. CalPERS is the agency charged with administering the Public Employees' Medical and Hospital Care Act (PEMHCA). (Gov. Code, § 22750 et seq.) PEMHCA authorizes and requires the Board of Administration of CalPERS to provide health benefits for state employees, dependents, annuitants, as well as for employees and annuitants of contracting public agencies which elect to contract with CalPERS for health benefit coverage.

3. At all times pertinent to this case Blue Shield of California was a health maintenance organization plan offered by CalPERS to individuals eligible for health care benefits under PEMHCA. CalPERS contracted with Blue Shield of California to administer Blue Shield of California's medical claims.

4. Edward Moore (respondent) was eligible for health benefits under PEMHCA by virtue of his spouse's employment with the California Department of Transportation, and was enrolled in the Blue Shield of California health plan effective June 1, 2005.

Background

5. Respondent suffers from a rare voice disorder known as spasmodic dysphonia (SD). He was diagnosed with this condition on May 8, 2008, following an otolaryngology evaluation by Mark S. Courey, M.D., Director, Division of Laryngology, and Professor, Department of Otolaryngology, University of California, San Francisco Medical Center. SD is a neurological disorder affecting the voice muscles in the larynx, or voice box. In SD, the muscles inside the vocal folds within the larynx experience sudden involuntary movements (spasms) which interfere with the ability of the folds to vibrate and produce voice. SD causes voice breaks and can give the voice a tight, strained quality. There are three types of SD: 1) adductor spasmodic dysphonia, 2) abductor spasmodic dysphonia, and 3) mixed spasmodic dysphonia. Respondent was diagnosed with abductor SD, a condition characterized by spasms that cause the vocal folds to open, and when opened too far the vocal folds cannot vibrate. As a result, the voice of those with abductor SD sounds weak and breathy.

6. In a report dated May 13, 2008, Dr. Courey described respondent's symptoms and treatment options as follows:

It appears that the above-captioned patient has strained strangled voice with complete stops and a sense of increased effort. His symptoms appear to resolve with rest. These vocal stops are more prominent on vowel-like sounds and this is consistent with abductor spasmodic dysphonia with variant of chronic constriction. This was discussed at length with patient. The role of speech therapy, botulinum toxin therapy, and surgery as management options were all discussed. The patient appeared rather distressed by his diagnosis of a movement disorder. He

wanted to consider his options and he was given the contact information for the National Spasmodic Dysphonia Association.

7. Respondent chose conventional speech therapy. His primary care physician, Garth B. Tanner, M.D., had referred him to Linda Reece, MA, CCC-SLP for speech therapy. He continued seeing Ms. Reece for approximately two years from 2007. Respondent noted that speech therapy was somewhat beneficial in helping him cope, but he believed his speech and voice continued to “quickly digress.” By October 2009, respondent returned to Dr. Tanner with complaints that speech therapy was not helping and that his SD symptoms were worsening.

8. On October 2, 2009, Dr. Tanner evaluated respondent and determined to “[s]eek authorization for referral to Dr. Cooper.” Morton Cooper, Ph.D., is a speech pathologist who specialized at that time in SD and voice disorders. Dr. Cooper pioneered and provided a therapy/treatment for SD known as Direct Voice Rehabilitation (DVR). Dr. Cooper is now retired. Having respondent see Dr. Cooper was also one of the three treatment options initially recommended by Dr. Courey. In Dr. Courey’s earlier notes from his May 2008 visit with respondent, he did not distinguish Dr. Cooper’s services from speech therapy. For example, Dr. Courey described his initial plan and treatment options for respondent as “Discussed Cooper v. Botox vs. Surgery.” Dr. Cooper was not a contracted provider with Blue Shield.

9. On or about October 2, 2009, Dr. Tanner made a request to AllCare, the agent of Blue Shield of California responsible for reviewing requests for referral to an out of network provider, for referral to Dr. Cooper.

10. By letter dated October 7, 2009, AllCare informed respondent that his request to render DVR services with Dr. Cooper was denied based on lack of medical necessity and the fact that Dr. Cooper was a non-contracted provider. AllCare explained in its denial letter:

The AllCare Medical Guideline for Specialty and Tertiary Referral requires that referrals be made to contracted providers unless services needed are emergent or not available from a contracted provider. Morton Cooper, Ph.D. is not a contracted provider with AllCare and with Blue Shield. Based on clinical information provided, this routine service can be safely provided by a contracted tertiary provider. Therefore, the service is denied.

An authorization for an office consultation has been issued to Edward Damrose, M.D., at Stanford Hospital and Clinics. Dr. Damrose is a contracted Otolaryngologist who specializes in voice and swallowing disorders. Please contact your primary care physician to arrange an appointment with Dr. Damrose or to determine an effective alternative for your care.

11. Between October 5, 2009, and October 30, 2009, respondent nevertheless received DVR services from Dr. Cooper. Respondent described extensive DVR treatments in Dr. Cooper's Los Angeles clinic for five days a week, both in individual and group sessions. Respondent explained that DVR treatment addresses the unique challenges of SD by: 1) raising the pitch and shifting the tone focus for the lower throat (where the spasms occur) to the upper throat and into the face (from laryngeal to facial resonance); 2) learning diaphragmatic breath control rather than thoracic breathing; 3) limiting volume so as not to try to push one's voice out triggering spasms; and 4) creating a new voice identity rather than the patient identifying with the "strangled" sounding voice. DVR is intensive, requiring five hours of drills a day with Dr. Cooper monitoring and facilitating the therapy. DVR requires determined and active patient participation in the treatment process. Patients continue to follow instructions and specific exercises even after formal therapy has been completed and they have returned home. Respondent paid \$20,000 out-of-pocket for the DVR treatment he received from Dr. Cooper, and for which he now seeks reimbursement.

Appeals

12. Respondent has pursued three levels of appeal, all unsuccessful, from AllCare's initial denial of an out of network referral to Dr. Cooper. He appealed first to Blue Shield of California, then to the Department of Managed Health Care, and finally to CalPERS administrative review. The three appeals are briefly summarized below.

13. Blue Shield of California. On October 7, 2009, respondent grieved AllCare's denial to Blue Shield of California, confirmation of which was acknowledged on October 12, 2009. By letter dated November 4, 2009, Blue Shield of California informed respondent that coverage of DVR was denied on the grounds that the requested provider was a non-contracted provider and that the requested service was not medically necessary. Blue Shield of California explained in its letter:

It has been determined that we cannot authorize your request to see Morton Cooper, Ph.D., Speech Therapist regarding your Spasmodic Dysphonia. The principal reason for the denial is that this provider is not affiliated with your medical group. Blue Shield has obtained information indicating that your medical group has an affiliated otolaryngology specialist, with subspecialty interest and experience in voice, Dr. Edward Damrose, at Stanford University, to provide your care. Specifically, the clinical rationale for the denial is as follows: There is no medical documentation leading to the conclusion that the affiliated specialist cannot provide the specific medically necessary services that you require, and consistent with the standards of care within the medical community.

Blue Shield of California noted that if Dr. Damrose believed respondent would benefit from Speech Therapy, that service would be requested. It further explained its reservations about Dr. Cooper's DVR therapy as follows:

However, there is insufficient evidence in the peer reviewed medical literature to conclude the claims made by Morton Cooper, Ph.D., related to "cures" resulting from his type of therapeutic intervention is superior to alternative techniques. Finally, if Dr. Morton believes that your Spasmodic Dysphonia is not a medical condition, but rather a voice habit requiring behavioral modification (as his website appears to indicate), then the management of this condition would be excluded from coverage under the terms of your Evidence of Coverage, and Blue Shield of California medical necessity criteria.

14. California Department of Managed Health Care (DMHC). On November 27, 2009, respondent submitted an Independent Medical Review (IMR) Application to DMHC of Blue Shield of California's denial of his request for DVR services from Dr. Cooper. DMHC then assigned the IMR to MAXIMUS Center for Health Dispute Resolution. On March 5, 2010, MAXIMUS upheld the decision by Blue Shield, determining that the requested services were not medically necessary for treatment of respondent's medical condition. In the Analysis and Findings portion of its IMR reviewer report, the independent otolaryngologist selected by MAXIMUS noted:

The patient has been diagnosed with spasmodic dysphonia which is a difficult condition to treat effectively. Although the provider states in his letter that direct voice rehabilitation is a cure for spasmodic dysphonia and cites case reports of benefit, there is no outcome data in the scientific literature which supports this contention. There have been no published controlled studies supporting the use of direct voice rehabilitation for treatment of patients with spasmodic dysphonia. The scientific data is replete with studies regarding the use of botulinum toxin (Botox) for this condition and it is well-accepted that this is the most commonly used treatment. In addition, there are published results demonstrating the positive outcomes in patients who have undergone surgical repair, although these studies involve small numbers of patients studied. All told while there are limited options in this setting, there is greater support for the efficacy of Botox and surgical intervention than direct voice rehabilitation, which has not been subject of peer-reviewed studies. In the absence of evidence of benefit, the medical necessity of direct voice rehabilitation has not been established. Accordingly, I have determined that the

requested services are not medically necessary for treatment of the patient's medical condition.

By letter dated March 8, 2010, MAXIMUS informed respondent that its "independent provider determined that the service you requested is not medically necessary."

15. CalPERS Health Benefits Division. On March 31, 2010, respondent appealed Blue Shield of California's denial of the claim for reimbursements for DVR to the CalPERS Health Benefits Division. On December 15, 2010, CalPERS advised respondent that after review of available medical records and related documentation it was upholding Blue Shield of California's denial of the claim for reimbursements for DVR. Respondent indicated that he did not receive CalPERS's denial letter until July 1, 2011.

On July 27, 2011, respondent appealed the CalPERS determination and requested an administrative hearing. By letter dated August 2, 2011, CalPERS acknowledged receipt of the request for hearing and accepted respondent's appeal.¹

16. As set forth in the Statement of Issues, CalPERS indicated that the issue to be resolved in this case is whether Blue Shield of California complied with the terms of the Evidence of Coverage in denying respondent's request for coverage of DVR provided by Dr. Cooper, a non-contracted provider.

Evidence of Coverage

17. Blue Shield of California provided respondent with an Evidence of Coverage (EOC) for calendar year 2009. The EOC contained the terms and conditions of the plan including provisions concerning benefits, claims and payment of claims. (Cal. Code Regs., tit. 2, § 599.508, subd. (a)(6).) The 2009 EOC did not cover DVR when not medically necessary.

18. Referrals. The EOC provided that the member's personal physician "coordinates with your designated medical group or IPA to direct all of your medical care needs and refer you to specialists or hospitals within your designated medical group or IPA unless because of your health condition, care is unavailable within the medical group or IPA." (EOC, p. 7.) The EOC confirmed the paramount relationship and role of the member's personal physician, noting that the "best effort of your Personal Physician will be used to ensure that all medically necessary and appropriate professional services are provided to you in a manner compatible with your wishes." (EOC, p. 9.) For referrals to specialty

¹ CalPERS subsequently declined respondent's request for an administrative hearing by letters dated June 20, 2013, and August 27, 2013. The reason then given was that respondent's case involved only a benefit issue. By letter dated January 22, 2014, CalPERS acknowledged after further reconsideration that this case involved both medical necessity and benefit issues. It reinstated respondent's right to an administrative hearing at that time.

services, the member's personal physician is responsible for coordinating and directing the member to required specialty services. The EOC provided in this regard:

Your Personal Physician will generally refer you to a Plan specialist or Plan non-physician health care practitioner in the same medical group or IPA as your Personal Physician, but you can be referred outside the medical group or IPA if the type of specialist or non-physician health care practitioner needed is not available within your Personal Physician's medical group or IPA. Your Personal Physician will request any necessary prior authorization from your medical group or IPA.

(EOC, p. 10.) Regarding referrals for a second opinion about care received from a specialist, the EOC provided that the second opinion may be provided by any Plan specialist of the same or equivalent specialty, and that all second opinions must be authorized. (*Ibid.*) Importantly, the EOC specified that referral by a member's Personal Physician "does not guarantee coverage for referral services." (EOC, p. 11.) In all cases the eligibility provisions, exclusions and limitations "will apply." (*Ibid.*)

The EOC imposed liability on members for payment of any unauthorized services. Thus, it required: "The Member will be responsible for payment of services that are not authorized or those that are not emergency or covered out of service area urgent service procedures." (EOC, p. 16.) Members were further advised: "If your condition requires services which are available from the Plan, payment for services rendered by non-Plan providers will not be considered unless the medical condition requires emergency or urgent services." (EOC, pp. 16-17.)

19. Medically Necessity. The EOC contains a Medical Necessity Exclusion section which provides as follows:

All services must be medically necessary. The fact that a physician or other provider prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services which are not medically necessary.

(EOC, p. 46.)

20. The EOC defines "Medically Necessary" in pertinent part as follows:

1. Benefits are provided only for services which are medically necessary.

2. Services which are medically necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield are:

- a. consistent with Blue Shield medical policy; and,
- b. consistent with the symptoms or diagnosis; and
- c. not furnished primarily for the convenience of the patient, the attending physician or other provider; and
- d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

3. If there are two or more medically necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.

[¶] ... [¶]

5. Blue Shield reserves the right to review all services to determine whether they are medically necessary.

(EOC, p. 115.)

Medical Necessity Evidence

21. CalPERS Medical Review. Like Blue Shield, CalPERS contractually assigned its request for IMR to the MAXIMUS Center for Health Dispute Resolution. It did so as part of its administrative review process. CalPERS understood that MAXIMUS had previously performed an IMR for DMHC. (Finding 14.) Accordingly, the second IMR was made by an independent medical professional who had no affiliation with Blue Shield of California and who was not a physician specializing in otolaryngology. Rather, the reviewer was actively practicing and was a licensed speech-language pathologist. The second MAXIMUS reviewer upheld the denial, finding that DVR services were not medically necessary. The reviewer concluded:

All told, direct voice rehabilitation was not medically necessary for treatment of the patient's medical condition. Botox injections combined with speech therapy are standard modalities in this setting. Vocal function exercises and resonant voice

therapy are also considered acceptable practice. With spastic dysphonia, more respiratory work is necessary to develop better control and coordination of airflow and phonation. Direct voice rehabilitation is not considered standard of care in this setting.

22. Nandini Nerayan, M.D., testified at hearing. She is employed as a medical consultant with CalPERS's Health Plan Administration Division. Dr. Nerayan is responsible for the review of medical records during the health appeals process, including evaluation of medical necessity. She was assigned to make such evaluation in this case in late 2014. Dr. Nerayan completed a pediatrics fellowship. She is not an otolaryngologist.

Relying largely on the earlier IMR reports and a short report by a second CalPERS reviewing physician, Dr. Nerayan concluded that there was no consensus among experts in the field supporting the use of DVR for treating SD. She noted that the initial MAXIMUS reviewer and others had cited to journal articles that supported her own determination that speech therapy, Botox injections and surgery were generally accepted therapy/treatment for SD, but that DVR was not. Dr. Nerayan does not consider DVR to be a form of speech therapy. However, she also acknowledged that the type of speech therapy one would use to treat SD is beyond her expertise. She did not clarify why DVR was not a type of speech therapy. She noted that there are no published controlled studies by Dr. Cooper or anyone else regarding the effectiveness of DVR, and that what few references there are in the literature to DVR are largely anecdotal accounts and testimonials to the treatment's effectiveness.

23. Respondent's Testimony. Respondent has an educational background in psychology. He worked as a school counselor and case manager, occupations where speech is very important. By 2009, he lost his job because he could not communicate clearly and effectively.

When Dr. Courey first diagnosed him with SD, respondent carefully considered the three treatment options. He did not want surgery. In part, he believed that a surgery he underwent in May 2007 for treatment of sleep apnea may have caused the SD. Dr. Courey had also advised respondent that surgery would be complicated and that there was no guarantee that the SD symptoms would be alleviated. There was also a danger that nerve re-nerivation surgery would cause irreparable nerve damage.

Respondent also opted against Botox injections. He understood that Botox injections cost \$1,000 each, and would need to be administered anywhere from every three weeks, to every six months, depending upon the response. He was concerned as well that this was an off-label use of this drug and "not approved by the FDA for injections into the vocal cord for SD." Respondent also understood that Botox shots were anatomically impossible to inject in the same site twice with the correct dosage, and could cause degenerative tissue damage over a prolonged period of time.

Respondent opted for conservative speech therapy through Linda Reece, which was covered by Blue Shield's plan. He was started on a weekly, then a bi-weekly program. As noted in Finding 7, by October 2009, respondent felt that the speech therapy was having minimal results, and that his SD symptoms were worsening. He noted that Ms. Reece did not specialize in SD, and that he was her first SD patient. Even after Blue Shield denied his referral to Dr. Cooper, he decided to pursue DVR treatments from October 5, 2009, through October 30, 2009.

24. Respondent went through intensive DVR sessions with Dr. Cooper, focused on changing his tone from the lower to upper throat, and learning to breathe through his diaphragm instead of upper body. He felt the process was very empowering as DVR was therapy done "with" as opposed "to" him. He made very good progress and has continued to utilize DVR exercises and techniques to present. Respondent believes that the DVR he received was medically necessary, cost-effective and had good results.

Discussion

25. Respondent has articulated the reasons for pursuing DVR as he did. He believes he pursued a conservative course of treatment for SD and he is satisfied with the results. The burden is on respondent to demonstrate that DVR was medically necessary for the treatment of his SD. Blue Shield of California's EOC provided that services which are medically necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition. The EOC further provided that if there are two or more medically necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.

Respondent failed to establish that the DVR services furnished by Dr. Cooper were in accordance with generally accepted professional standards to treat SD. Two IMRs and Dr. Nerayan agree that neither published controlled studies nor peer-reviewed journal articles in medical/professional literature support DVR as being generally accepted within the medical community as an effective and recognized therapy/treatment for SD. That good treatment results may be documented anecdotally, or seen in respondent's specific case, does not change this. It may well be that in time DVR will become a generally accepted treatment modality. However, that does not appear to be the case today. Nor has respondent established that DVR is merely another form of speech therapy. In this regard it is noted that the second IMR was performed by a licensed speech-language pathologist who concluded that Botox injections combined with speech therapy was the standard treatment modality. Apparently, vocal function exercises and resonant voice therapy are also considered acceptable practice. However, the speech-language pathologist did not characterize DVR as a form of speech therapy, and specifically opined that "[d]irect voice rehabilitation is not considered standard of care in this setting."

26. Even were DVR found to be medically necessary, the EOC provides that Blue Shield of California, where there are two or more medically necessary services, is bound

only to provide benefits based on the most cost-effective service. Respondent has not established that DVR is the most cost-effective service. For example, Botox injections cost \$1,000, but such could be administered as little as twice a year. Respondent's suggestion that it might be required every three weeks is speculative. And his further suggestion that it is not available to him as a treatment option because it is an off-label is without evidentiary support. Respondent offered no evidence on the relative cost of surgery. For these several reasons, respondent has not demonstrated through competent evidence that DVR was the most cost-effective service among the treatment options before him.

27. Respondent was fully within his rights to select what he believed to be his best treatment option. He was placed on early notice that his request for referral to Dr. Cooper was being denied. He chose to pursue DVR treatments knowing that Blue Shield of California had already determined that such were not medically necessary.

Given the above findings that DVR was not a medically necessary service for the treatment of SD, and that it was not the most cost-effective treatment option, respondent's appeal should be denied. Blue Shield of California complied with the EOC terms in denying coverage of DVR provided by Dr. Cooper, a non-contracted provider.

LEGAL CONCLUSIONS

Applicable Statutes and Regulations

1. CalPERS is the agency charged with administering the Public Employee's Medical and Hospital Care Act. (Gov. Code, § 22750 et seq.) It shall have "all powers reasonably necessary to carry out the authority and responsibilities expressly granted or imposed upon it under this part." (Gov. Code, § 22794.)

2. Government Code section 22848 provides:

An employee or annuitant who is dissatisfied with any action or failure to act in connection with his or her coverage or the coverage of his or her family members under this part shall have the right of appeal to the board and shall be accorded an opportunity for a fair hearing. The hearings shall be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3.

Determination

3. The applicable Blue Shield of California Evidence of Coverage defines "Medically Necessary" in pertinent part as follows:

1. Benefits are provided only for services which are medically necessary.

2. Services which are medically necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield are:

- a. consistent with Blue Shield medical policy; and,
- b. consistent with the symptoms or diagnosis; and
- c. not furnished primarily for the convenience of the patient, the attending physician or other provider; and
- d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

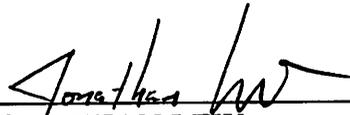
3. If there are two or more medically necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.

4. Respondent has the burden on appeal of demonstrating that Blue Shield of California failed to comply with the terms of its EOC in denying his request for coverage of DVR. The matters set forth in Findings 17 through 27 have been considered. It was not established by competent evidence that DVR was a medically necessary service for the treatment of SD. DVR was also not the most cost-effective treatment option. For these reasons, Blue Shield of California complied with the EOC terms in denying coverage of DVR provided by Dr. Cooper, a non-contracted provider. Respondent's appeal should be denied.

ORDER

The appeal of respondent Edward Moore is **DENIED**.

DATED: March 12, 2015



JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings