OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 88-449 - July 1, 1992

Board of Trustees: Joseph P. Connors, Sr., Chairman; Paul R. Dean, Trustee; William Miller, Trustee; Elliot A. Segal, Trustee.

Pursuant to Article IX of the United Mine Workers of America ("UMWA") 1950 Benefit Plan and Trust, and under the authority of an exemption granted by the United States Department of Labor, the Trustees have reviewed the facts and circumstances of this dispute concerning the provision of assistant surgeons, pathology and emergency room evaluations under the terms of the Employer Benefit Plan.

Background Facts

The Employee's daughter was involved in an automobile accident on July 22, 1990 where she was ejected from the vehicle and suffered multiple, fairly severe, skin injuries and a head injury. During her course of treatment she had a seizure at the local hospital where she was originally taken, necessitating a transfer to a hospital facility better equipped to handle her injuries, and where she could receive definitive treatment since she was deteriorating neurologically due to a left parietal occipital epidural hematoma. There she underwent multiple surgical procedures to treat her injuries.

She has exhausted the policy limit under the Personal Injury Protection portion of the automobile policy. The remaining bills were submitted to the Employer's insurance company which paid the majority of the bills. The Employee contends, however, that the following bills were denied improperly, and has asked for a review of these charges:

(1) A $250 assistant surgeon charge incurred on July 22, 1990. This charge was denied because the insurance company determined that this surgery (procedure code 13121) does not require an assistant surgeon.

(2) A $22 gross microscopic examination/pathology charge for services rendered July 22, 1990. This charge was denied as the insurance company determined that it should have, been included with the surgical fee.

(3) A $144 charge for a comprehensive hospital admission history and physical (procedure code 90220). The insurance company stated this charge should have been included in the total surgical allowance.

(4) A $75 charge on July 22, 1990 for a new-patient, emergency room service (procedure code 90517). This charge, as well, was determined to be ineligible as the services performed should have been included in the total surgical fee.

The Employer maintains that the charges were properly denied. In reference to the $250 assistant surgeon's fees, the Employer states that the condition and the type of surgical procedure did not require a surgical assistant. Additionally, the Employer states that the charges for pre-operative and post-operative history and physicals should be included in the total surgical allowance. The Employer denied the $22 pathology charge because it determined that it, too, should be billed as part of the surgeon's fee. Finally, the Employer states that it will not hold the Employee harmless for these services since they were properly denied by the carrier.

Dispute

Is the Employer required to pay for the charges incurred by Employee's daughter for an assistant surgeon, a pathology examination, and two medical evaluations, on July 22, 1990?

Positions of the Parties

Position of the Employee: The Employer is responsible for payments of the disputed services as they were medically necessary to treat injuries sustained in an accident that occurred while the patient was covered under the Plan. If the Employer continues to deny benefits for these services, it should hold the Employee harmless from any attempts to collect these charges.

Position of the Employer: The Employer is not responsible for the payment of the disputed charges as its carrier has made proper denials, and as such, will not hold the Employee harmless for these services.

Pertinent Provisions

The Introduction to Article III states:

Article III - Benefits

Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. The fact that a procedure or level of care is prescribed by a physician does not mean that it is covered under this Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided. Services which are not

reasonable and necessary shall include, but are not limited to, the following: procedures which are of unproven value or of questionable current usefulness; procedures which tend to be redundant when performed in combination with other procedures; diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly; procedures which are not ordered by a physician or which are not documented in a timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care. Covered services that are medically necessary will continue to be provided, and accordingly this paragraph shall not be constructed to detract from plan coverage or eligibility as described in this Article III.

Article III. A. (1) (a) states:

A. Health Benefits

(1) Inpatient Hospital Benefits

(a) Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter "physician") for treatment as an inpatient to an Accredited Hospital (hereinafter "hospital"), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary's condition.

Medically necessary services provided in a hospital include the following:

Operating, recovery, and other treatment rooms
Laboratory tests and x-rays
Diagnostic or therapy items and services
Drugs and medication (including take-home drugs which are limited to a 30-day supply)
Radiation therapy
Chemotherapy
Physical therapy
Anesthesia services
Oxygen and its administration
Intravenous injections and solutions
Administration of blood and blood plasma
Blood, if it cannot be replaced by or on behalf of the Beneficiary

(3) Physicians' Services and Other Primary Care

(a) Surgical Benefits

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedures (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

When surgical services consist of necessary major surgery (primary) and the physician performs surgery additional to the primary surgery (incidental surgery), benefits payment for the incidental surgery will be provided but at a rate 50% lower than the physician's normal charge had he performed only the incidental surgery.

Article III. A. (3) (b) states

(b) Assistant Surgeons

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

Article III. A. (3)(g) states:

(g) In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has a separate and complicated condition, the treatment of which requires skills not possessed by the physician who is rendering the surgical, obstetrical or radiation therapy services.

Article III. A. (10)(g) 3. states:

3. The Employer and the UMWA agree that excessive charges and escalating health costs are a hint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Plan Administrator or his agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. Whether the Plan Administrator or his agent negotiates a resolution of a matter or defends a legal action on a Beneficiary's behalf,

> the Beneficiary shall not be responsible for any legal fees, settlements, judgments or other expenses in connection with the case, but may be liable for any services of the provider which are not provided under the Plan. The Plan Administrator or his agent shall have sole control over the conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

Article III. A. (11) (a) 12. states under General Exclusions:

> 12. Excessive charges.

Discussion

The Introduction to Article III states covered services will be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at an appropriate level of care. It continues to say that the fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary, or that it is covered under this Plan. Article III. A. (1) (a) provides that when a Beneficiary is admitted to a hospital by a licensed physician that benefits will be provided for a semi-private room and all medically necessary services and supplies provided by the hospital for the diagnosis and treatment of the Beneficiary's condition. Included on the list of medically necessary services are laboratory tests and x-rays. Article III. A. (3) (a) provides surgical benefits for services essential to a Beneficiary's care, and Article III. A. (3) (b) provides benefits for an assistant surgeon when the condition of the Beneficiary and type of surgical service requires such assistance. Article III. A. (3)(g) states that while a beneficiary is confined as an in-patient in a hospital due to an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Additionally, it states that these benefits will be provided concurrently with benefits for surgery when the Beneficiary has a separate and complicated condition and the treatment of which requires skills not possessed by the physician who is rendering the surgical services.

A Funds' medical consultant has reviewed the file to include a limited portion of the hospital records. No letters or operative reports were submitted from the treating physicians.

Regarding the $250 charge for an assistant surgeon, the consultant is of the opinion that the services of an assistant surgeon would not normally be medically required for the procedure code 13121. No documentation was received from either surgeon regarding the medical necessity for the assistant surgeon's charge. In the absence of any supporting documentation, it is the opinion of the consultant that this charge is for services that would be considered medically unnecessary.

The pathology report received from the physician performing the evaluations indicates that there were two distinct specimens received on July 22, 1990. One was from the right temporal laceration, on which he did both a gross and microscopic examination, and billed under code 88304. The second specimen, from the left parietal occipital craniotomy, involved only a gross

examination of the hematoma, and was billed under the code 88300. Neither procedure could be billed as part of the surgical fee, as was suggested by Blue Cross/Blue Shield, since the surgeon himself did not perform the pathological examinations on the tissue specimens. The consultant is of the opinion that since two different specimens from two different sites were submitted, and since both surgical procedures were medically necessary, both charges should be considered covered expenses.

The comprehensive hospital admission and physical ($144) included the preparation of medical records for admission. This was performed by the surgeon who did the cranial and scalp surgery. The general evaluation of the patient, the history and physical examinations, and attendent paperwork cannot be included in the surgical fee billed by the neurosurgeon. The patient had suffered multiple injuries as a major trauma patient and required a full evaluation of all body systems prior to admission. The CPT codes for the surgical procedures assume a stable, non-emergent patient, and do not account for the evaluation and admission of an emergent multiple trauma patient. The Fund's medical consultant is of the opinion that the evaluation billed under CPT code 90220 was medically necessary and was a distinct and separate procedure from the surgery performed.

Regarding the $75 charge for a new-patient, emergency room service (CPT code 90517); under the circumstances of a major emergency/accident, it would be a common practice of third party payors to provide benefits for this charge. Since the Employee's daughter's injuries were severe and potentially life-threatening, and her condition was such that it necessitated transport to another facility, a new assessment was appropriate. Therefore, the Employer is required to provide benefits for the emergency room evaluation under Article III. A. (3)(g) of the Employer Benefit Plan.

Article III. A. (11) (a) 12. states under General Exclusions that excessive charges would be ineligible under the Plan. A distinction must be made between charges that the Plan does not cover under any circumstances, and charges that the Plan would cover in certain situations, and under certain circumstances. In this case, the assistant surgeon is being denied on the grounds of medical necessity. An assistant surgeon is provided for under the provisions of the Plan in situations where the condition of the Beneficiary and the type of surgical service require such assistance. Without any supporting documentation from the doctors performing the surgery, the assistant surgeon's charge was deemed to be medically unnecessary in this instance, and therefore ineligible under the Employer Benefit Plan.

Article III. A. (10)(g) 3. of the Employer Benefit Plan states that the Employer is required to hold the Employee harmless from any attempts the provider of service may make to collect excessive charges or charges not medically necessary. The Plan states that the Employer, with the written consent of the Beneficiary, will attempt to resolve the matter either by negotiating a resolution or defending any legal action commenced by the provider. Regardless of the type of resolution, the Beneficiary will not be responsible for any legal fees, settlements, judgements or other expenses in connection with the case but may be liable for any services of the provider which are not provided for under the Plan. The use of the assistant surgeon would be covered

under the Plan under different circumstances, but in this case, has been found to be not medically necessary. While the Employer is not required to provide benefits for this service, the Employer is required to implement hold harmless procedures for the $250 assistant surgeon's charge for July 27, 1990.

Opinion of the Trustees

The Employer is required to provide benefits for the $22 pathology charge, the $144 comprehensive history and physical charge, and the $75 emergency room service charge incurred on July 22, 1990. Furthermore, the Employer is required to implement hold harmless procedures for the $250 assistant surgeon's fee in accordance with Article III. A. (10)(g) of the Employer Benefit Plan.