OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 81-553 - August 27, 1985

Board of Trustees: Joseph P. Connors, Sr., Chairman; Paul R. Dean, Trustee; William B. Jordan, Trustee; William Miller, Trustee; Donald E. Pierce, Jr., Trustee.

Pursuant to Article IX of the United Mine Workers of America 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 payment of emergency room charges and hereby render their opinion on the matter.

Background Facts

The Complainant is an active mine worker eligible for health benefits under the Employer Benefit Plan. His wife suffers from severe migraine headaches for which she has sought frequent emergency room care and treatment. Payment for emergency room care provided after March 18, 1984, for treatment of the Complainant's spouse's migraine headaches has been denied by the Respondent on the basis that (1) the services were being used to treat a chronic medical problem rather than a medical emergency, (2) the number of emergency room visits was excessive and constituted inappropriate utilization of those services and (3) the emergency room services constituted medically unnecessary treatment. The case record includes documentation of 131 emergency room visits from January 6, 1983, through March 10, 1984, the charges for which apparently were paid by the Respondent, and 34 emergency room visits from March 19, 1984, through October 28, 1984, the charges for which apparently were denied by the Respondent.

Dispute

Is the Respondent responsible for payment of charges resulting from emergency room care and treatment of migraine headaches?

Positions of the Parties

Position of the Complainant: The emergency room charges should be considered a covered benefit.

Position of the Respondent: The emergency room charges are not covered because (1] they were incurred for treatment of a chronic condition rather than for a medical emergency, (2) the number of emergency room visits in this case has been excessive and has constituted inappropriate utilization of these services, and (3) the emergency room services were not medically necessary.

Pertinent Provisions

Article III. A. (2) (a) of the Employer Benefit Plan (1981 and 1984) states:

> Benefits are provided if you or your dependent received emergency medical treatment of a sickness or of an injury as the result of an accident, provided such emergency medical treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

Question and Answer #81-10 provides:

> Subject: Definition of Emergency Treatment Benefit
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> References: Amended 1950 and 1974 Benefit Plans and Trusts, Article III, Sections A (2) (a) and A (3) (1)
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> Question:
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> Benefits are provided for emergency medical treatment or medical treatment of an injury as the result of an accident, provided the treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.
>
> 1. Would emergency treatment for conditions such as the following be covered under this provision:
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> - acute pain attributed to gout?
>
> - heart attack, severe chest pain, or congestive failure experienced by a patient with (chronic) heart disease?
>
> - intracranial bleeding or stroke experienced by a patient with hypertension?

2. Are benefits provided for inpatient and outpatient hospital and physicians' services following emergency treatment beyond the 48 hour initial care limit (for example, suture removal or cast removal)?

Answer:

1. Yes, because the symptoms are acute and require emergency treatment, even though the underlying illness causing the symptoms may be chronic.

2. Yes, if the follow-up treatment is covered under the Plan.

Question and Answer #81-85 provides:

Subject: Follow-up Care to Emergency Treatment

References: Amended 1950 and 1974 Benefit Plans and Trusts, Article III, Sections A (2) (a) and (3) (i)

Question:

1. A beneficiary requires follow-up services to emergency treatment which are rendered beyond the 48 hour initial emergency care limitation, and which are also rendered in an emergency room. Are benefits provided for both the medical treatment and the emergency room charges?

2. A beneficiary requires emergency room treatment and receives it within 48 hours of the onset of acute symptoms. After the 48 hour period has expired, the acute symptoms reappear. If the beneficiary goes to the emergency room for treatment within 48 hours of the reappearance of the acute symptoms, are benefits provided for both the medical treatment and the emergency room charges?

Answer:

1. In this situation, the charge for emergency room service is not covered. However, benefits will be provided for charges for medical treatment which is otherwise covered under the Plan.

2. Yes.

Article III of the Employer Benefit Plan (1984) provides:

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 medically reasonable or necessary or 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 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 construed to detract from plan coverage or eligibility as described in this Article III.

Discussion

The Respondent denied benefits in this case for three reasons: (1) coverage of emergency room services for treatment of a chronic medical problem, (2) the appropriateness of using emergency room services to treat the patient and (3) the medical necessity of the treatment which the patient has been receiving.

The first consideration is directly addressed by Q&A #81-10 and Q&A #81-85. Under Q&A #81-10, emergency room services are covered for the treatment of acute symptoms requiring emergency treatment, even though the underlying medical condition is chronic. Under Q&A #81-85, emergency room services are covered for the treatment of such recurring acute symptoms. The intractable pain which usually accompanies chronic migraine headaches is an example of a recurring acute symptom associated with a chronic medical condition. Based on the most straightforward issue of covered services, emergency room treatment for migraine headaches appears to be a covered benefit.

The Respondent also denied the charges, however, on the basis that the emergency room treatment was not medically necessary or appropriate. Both of these issues involve a patient's condition and regimen of treatment. In this case, the Respondent arranged for the beneficiary to have an independent consultant evaluate the Complainant's spouse's condition and regimen of treatment. The consultant, a neurologist, advised that the patient be taken off her current regimen of treatment, re-evaluated by means of an E.E.G., and started on a new regimen of treatment. The record includes a report by the Respondent's Insurance Coordinator of an oral discussion which he had with the Complainant's spouse's current attending physician. In that discussion, the attending physician stated that he saw no need for referral of the case to a neurologist and that he did not intend to follow the advice of the consulting neurologist. The

record also includes copies of emergency room records (from three different hospitals over a period of 21 months) which indicate that six different emergency room physicians, as well as a former attending physician, questioned the appropriateness of the regimen of treatment and raised the possibility that it, especially in its provision of different analgesic medications on a regular and frequent basis, might induce substance dependence in, and therefore be harmful to, the patient.

In light of the conflicting medical opinions on the necessity and appropriateness of the regimen of treatment being provided to the Claimant's spouse, the Respondent asked its insurance carrier to obtain an additional independent opinion. The insurance carrier accordingly referred the case to the Kentucky Peer Review Organization, which concluded that (1) although medical treatment of the patient's condition is necessary, frequent emergency room visits for provision of analgesic drugs are not appropriate; (2) the frequent provision of analgesic drugs apparently caused the patient to become substance dependent; and (3) the patient should be evaluated in order to determine the cause of, and establish a regimen of treatment for, her chronic medical problems, rather than continuing the practice of providing symptomatic relief through the use of potentially harmful analgesic drugs.

Based on the evidence in this case, the Trustees are of the opinion that the emergency room services provided to the spouse would be a covered benefit only if they were medically necessary and appropriate. Before denying benefits, however, the Respondent must be able to demonstrate that it has adopted and applied reasonable procedures for determining whether the emergency room treatments are medically necessary and appropriate. In this case, the Respondent obtained an independent opinion from a consulting neurologist and, when that opinion conflicted with the attending physician's opinion, obtained an additional independent opinion from a state Peer Review Organization. The Trustees are, therefore, of the opinion that the Respondent has applied reasonable procedures which establish that the services in question are not medically necessary and appropriate.

Opinion of The Trustees

The Respondent is not responsible for the payment of the emergency room charges in this case as they were not medically necessary and appropriate.