OPINION OF TRUSTEES

In Re

Complainant: Pensioner
Respondent: Employer
ROD Case No: 07-0023 – December 9, 2009

Trustees: Micheal W. Buckner, Daniel L. Fassio, and Michael H. Holland.

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of benefits under the terms of the Employer Benefit Plan.

Background Facts

The Complainant had surgery performed on varicose veins of his legs on June 12, 2007. Surgery was recommended by the treating physician because of edema in both legs and no relief following multiple courses of antibiotics. The Complainant claims that the referring physician received pre-authorization for the surgery. Operative notes describe the patient as massively obese, and pre-operative progress notes indicate the patient had bilateral lower extremity edema.

The Respondent refused benefits for this procedure citing no evidence of a trial of conservative management prior to performing surgery.

Dispute

Is the Respondent required to provide benefits for the surgery performed on the Complainant on June 12, 2007?

Positions of the Parties

Position of the Complainant: The Respondent is required to provide benefits for the surgery because the treating physician stated that the surgery was necessary and received pre-authorization.

Position of the Respondent: The Respondent is not required to provide benefits for the vein surgery because conservative treatments, such as compression stockings or weight loss, were not tried prior to performing surgery.

Pertinent Provisions

The introduction to Article III of the Employer Benefit Plan states:

> ARTICLE III BENEFITS
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> …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. The benefits described in this Article are subject to any precertification, prescription drug formulary (PDP) requirements, and other utilization review requirements implemented pursuant to Article IV. Covered services that are medically necessary will continue to be provided, and accordingly, while benefit payments are subject to prescribed limits, this paragraph shall not be construed to detract from plan coverage or eligibility as described in this Article III.

Article III A. (3) (a) states, in part:

> (3) Physicians' Services and Other Primary Care
>
> (a) Surgical Benefits
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> Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (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.

* * *

Article III A. (10) (h) of the Employer Benefit Plan states in pertinent part:

> (h) Explanation of Benefits (EOB) and Hold Harmless
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> 2. The Employer and the UMWA agree that excessive charges and escalating health costs are a joint 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.

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Discussion

The Complainant was first seen by the referring physician on January 26, 2007, at which time he was prescribed 14 days of antibiotics for pain and swelling in his legs. The notes from February 20, 2007, indicate the redness was gone, but that swelling remained. Complainant's weight was stated at 300 lbs. At this visit, the Complainant was referred to the physician who later performed the surgery.

On March 12, 2007, the Complainant saw the physician who ultimately performed the procedure. Adjustments were made to the Complainant's medications and he was told he needed to get his weight down to 225lbs. Complainant was sent for a venous ultrasound to determine blood flow.

On May 3, 2007, the Complainant returned to the referring physician to discuss options. Complainant's weight was stated as 314lbs. The procedure, a bilateral greater saphenous vein endoluminal radiofrequency, was performed on June 12, 2007.

When questions of medical necessity arise, the Funds relies on Medicare guidelines to determine if treatments or procedures are reasonable and customary. The Funds' Medical Director has determined that the Medicare guidelines for West Virginia were not followed prior to performing the procedure on the Complainant. Medicare coverage for the procedure in question is limited to those cases where symptoms persist despite conservative therapy, a minimum 3-month trial of conservative therapy has failed or was determined to not be feasible, and where duplex studies defining the anatomy of the saphenous veins demonstrate greater saphenous vein incompetence/reflux that correlates with the patient's symptoms.

It is the opinion of the Funds' Medical Director that the disputed procedure did not meet the criteria noted above and as such would be considered not medically necessary when performed.

Opinion of the Trustees

Consistent with the provisions of the Employer Benefit Plan, the Employer is not required to provide benefits for the procedure performed on the Complainant on June 12, 2007. Respondent is required to hold the Complainant harmless for the charges related to the surgery performed on June 12, 2007.