OPINION OF TRUSTEES

In Re

Complainant: Pensioners
Respondent: Employer
ROD Case No: 07-0075 – January 23, 2019

Trustees: Michael H. Holland, Marty D. Hudson, Michael O. McKown, and Joseph R. Reschini

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 Complainants are retirees of an out of business company that was last signatory to the 2002 NBCWA. The spouse of each Complainant was tested for the Human Papillomavirus ("HPV"), as part of their periodic gynecologic examination for cervical cancer. The Respondent administers the Employer Benefit Plan ("EBP") on behalf of the out of business company. The Respondent denied the charges for the HPV tests, noting that each HPV test was routine lab work that was part of a routine physical exam and was not covered under the provisions of the EBP. Additionally, the Respondent stated that neither HPV test showed evidence of being medically necessary. The Respondent further asserts that the Complainants failed to appeal the denials in a timely manner and, therefore, the charges remain denied.

Dispute

Is the Respondent required to pay for the charges associated with the HPV tests administered to the spouses of the Complainants?

Positions of the Parties

Position of the Complainants: The charge associated with HPV testing is a covered benefit under the provisions of the EBP. The medical services rendered to administer the HPV test, which can detect cervical cancer, were medically necessary.

Position of the Respondent: The Complainants are responsible for payment for their HPV tests. The claims were submitted using routine lab CPT codes, which are not covered unless medically

necessary for the diagnosis or treatment of a specific condition, illness, or injury. No evidence of medical necessity has been submitted by either party to the ROD. The denials were not appealed, and the time to file an appeal has expired.

Pertinent Provisions

Article III A.(3)(j), III A.(3)(o)2, and III A.(10)(b) of the 2002 Model EBP state in pertinent part:

> ARTICLE III BENEFITS
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> A. HEALTH BENEFITS
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> (3) Physicians' Services and Other Primary Care
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> (j) Laboratory Tests and X-rays
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> Benefits will be provided for laboratory tests and x-rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.
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> (o) Primary Medical Care – Miscellaneous
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> 2. Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.
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> (10) General Provisions
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> (b) Administration
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> The Plan Administrator is authorized to promulgate rules and regulations to implement and administer the Plan, and such rules and regulations shall be binding upon all persons dealing with the Beneficiaries claiming benefits under this Plan.

The Trustees of the UMWA Health and Retirement Funds will resolve any disputes, including excessive fee disputes, to assure consistent application of the Plan provisions under the 2002 Wage Agreement.

Discussion

Article III A.(3)(j) of the 2002 Model EBP provides coverage of laboratory tests, performed in a licensed laboratory, that are ordered by a physician for diagnosing or treating a condition. Further III.A.(3)(o)2 provides for "examinations for cancer" and "other screening and diagnostic procedures when medically necessary." The Funds' Medical Director has reviewed the files of both women and found that the screening tests for HPV ordered by the respective physicians for each woman were medically necessary.

The records reviewed showed that Complainant A's spouse received screening for HPV during a gynecological exam on June 28, 2016. She was 61 at the time of the test and had not previously been screened for the HPV virus. The records included the order for HPV screening. The claim for this testing was denied as not being a covered benefit. The cost of this test was $101.25 and has not been paid by any party. Complainant A did not appeal this denial with the Respondent and filed the instant ROD on July 26, 2017.

A review of the records for Complainant B's spouse revealed that she received screening for HPV during a gynecological exam on October 9, 2015. She was 59 at the time of the test and was not able to recall ever having this test previously. Medical records were requested from the prescribing physician but were not submitted. She reported that she had cryosurgery in 1984 for dysplasia of the cervix and has a family history of medically required hysterectomies. Her claim for this service was denied as not being a covered benefit. The cost of this test was $129.00, and she paid for this out of pocket. Complainant B did not file an appeal of the denial with the Respondent and filed the instant ROD on July 26, 2017.

It is the opinion of the Funds' Medical Director that HPV testing is a recommended and medically necessary part of a gynecological exam as a screening tool for cervical cancer. The Funds relies on Medicare guidelines to assess whether medical technology is investigational or is no longer investigational and covered as a medical benefit by Medicare as an accepted standard of medicine. In 2015, Medicare instituted nation-wide coverage for HPV screening for asymptomatic women between 30 and 65, once every 5 years. Medicare.gov defines "medically necessary" as "health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." The Respondent states that Medicare coverage for HPV testing is not relevant to this ROD because

the beneficiaries are not enrolled in Medicare. However, the fact that Medicare now covers HPV testing indicates the acceptance of this screening as a standard nationally-accepted preventative and diagnostic measure to determine cancer risk.

The Respondent states that had the screenings been "coded as part of a medically necessary examination and for purposes of diagnosis or treatment, such tests would have been covered by the Plan." A screen shot of the submission for Complainant B's spouse, however, shows CPT code Z12.4 - "Encounter for screening for malignant neoplasm of cervix," along with the code for the HPV screening, Z11.51, which is the code Medicare directs physicians to use for this testing. The HPV testing was medically necessary and the claim was incorrectly denied.

The Respondent states that neither Complainant followed the appeal process, and because the 180-day time frame for appealing denials has passed, the denials remain upheld. While there is no language in the 2002 Model EBP that expressly permits the employer to develop or maintain a binding 180-day appeal period for participants who have had medical services denied by the employer, Article III A(10)(b) of the 2002 Model EBP does permit the Respondent to establish rules and regulations to implement the plan. Accordingly, the 180-day period within which a participant must file an appeal of a denial of benefits, is not prohibited by the 2002 Model EBP.

There are no previous RODs addressing an Employer's right to limit the time for filing an appeal, However, the Trustees have concluded in previous RODs that an employer has the right to promulgate a binding time limitation on the submission of claims, so long as that time period was reasonable and was communicated adequately to the participants. See ROD 81-697 and ROD 88-667. A reasonable time requirement for pursuing any denial of a submitted claim is a similar, appropriate administrative rule for the plan. In this case the 180-day limit is reasonable and notice of the appeal period was included in the Respondent's Summary Plan Description.

Opinion of the Trustees

The Respondent is permitted to institute policies and procedures to administer its EBP that are reasonable and adequately communicated to EBP participants. Instituting an appeal period for the denial of a claim is an appropriate administrative measure. Therefore, even though pursuant to Article III A.(3)(j) and III A.(3)(o)2 of the 2002 Model EBP, the Complainants' spouses' HPV tests are covered benefits under the Plan, Complainants' failure to file a timely appeal of the denial of their claims with the Respondent is a permissible reason for the Respondent to deny the claims. The Respondent is not responsible for paying for either of the HPV tests.