OPINION OF TRUSTEES

In Re

Complainant: Retiree
Respondent: Employer
ROD Case No: 11-0136 – October 31, 2016

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 Complainant is a retiree of the Respondent and receives medical benefits coverage from the Respondent secondary to Medicare. The Complainant underwent implantation of an interspinous distraction device on May 5, 2015, to alleviate symptoms associated with spinal stenosis. Medicare covered the procedure and the Complainant was responsible for the coinsurance. The Respondent denied the charges for the procedure as experimental and, therefore, not a covered benefit.

Dispute

Is the Respondent required to pay the coinsurance for the interspinous procedure performed on May 5, 2015?

Positions of the Parties

Position of the Complainant: The charges for the interspinous procedure are a covered benefit under the Employer Benefit Plan. The Medicare Administrative Contractor's "Local Coverage Decision" for the state in which the Complainant resides has determined that this procedure is covered and not experimental.

Position of the Respondent: The Respondent cited Highmark's policy that the procedure is experimental as a basis for the denial.

Pertinent Provisions

Article III of the Employer Benefit Plan 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 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.
>
> * * *

Article III.A(11)(a)24 of the Employer Benefit Plan states:

> III A. Health Benefits
> (11) General Exclusions
>
> (a) In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:
>
> 24. Charges for treatment with new technological medical devices, therapy which are experimental in nature.

Discussion

Article III of the Employer Benefit Plan states that benefits will be provided for medically reasonable and necessary procedures ordered by a physician for the treatment of an illness or injury. When there is a question relating to whether the procedure is reasonable or necessary, the Employer Benefit Plan will take into consideration the customary practices of the physicians in the community in which the procedure is performed.

The Funds' Medical Director has reviewed the Complainant's file and Medicare coverage policy. It was determined that the Medicare Administrative Contractor's "Local Coverage Decision," for the state in which the Complainant resides, considers the Complainant's procedure a covered benefit and not experimental. For this reason, Medicare covered the Complainant's interspinous procedure.

Article III of the Employer Benefit Plan, requires the Respondent to take into consideration the customary practices of the physicians in the Complainant's community. Medicare's coverage of the procedure is an indicator of the reasonableness and necessity of said procedure. Thus, the Respondent, as secondary medical insurance provider, should be responsible for payment of the coinsurance for the procedure.

Opinion of the Trustees

Pursuant to Article III of the Employer Benefit Plan, the Respondent is required to pay the coinsurance for the procedure performed on May 5, 2015.