OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 249, March 24, 1982

Board of Trustees: Harrison Combs, Chairman; John J. O'Connell, Trustee; Paul R. Dean, 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 Employee's eligibility for medical benefits from the Employer and hereby render their opinion on the matter.

Background Facts

In 1976, the Employee's wife suffered a slight stroke. She was admitted to a Multi-Care Facility where she suffered another, more severe, stroke that left her quadriplegic and aphasic. She was then transferred to a hospital in Charlottesville, Virginia, where she remained for three months. Subsequently, she returned to the Multi-Care Facility for one month and then went home, where her husband cared for her for the next three years. During that period, she spent about eight months in a Rehabilitation Center, but rehabilitation efforts were unsuccessful. On February 15, 1980, she was re-admitted to the Multi-Care Facility where she remained until June 17, 1981, when she was discharged to a hospital. The Employer's insurance carrier paid for the Employee's wife's care at the Multi-Care Facility from the date of her admission until November 30, 1980. The insurance carrier refused payment for services provided after November 30, 1980, on the basis that the services provided after that date were custodial in nature.

In the Multi-Care Facility, the patient required assistance with transfers, lifting, turning, positioning, bathing and feeding. In addition, she had a Foley catheter which had to be changed every two weeks. She received physical therapy from Monday through Friday. The patient's attending physician has stated that the level of care received by the patient is "intermediate custodial care."

Question or Dispute

Is the insurance carrier responsible for payment of the services received by the patient from December 1, 1980 through June 17, 1981?

Pertinent Regulations

Article III, Section A (5)(a)(b):

(5) Skilled Nursing Care and Extended Care Units

(a) Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

1. skilled nursing care provided by or under the supervision of a registered nurse;
2. room and board;
3. physical, occupational and speech therapy, either provided or arranged for by the facility;
4. medical social services;
5. drugs, certain immunizations, supplies, appliances and equipment ordinarily furnished by the facility for the care and treatment of inpatients;
6. medical services, including services provided by interns or residents in an approved, hospital-run training program, as well as other diagnostic and therapeutic services provided by the hospital and
7. other health services usually provided by skilled nursing care facilities.

The Plan will not pay for services in a nursing care facility:

1. that is not licensed or approved in accordance with state law or regulations;
2. unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions:

Telephone, T.V., radio, visitor's meals, private rooms or private nursing (unless necessary to preserve life), custodial care, services not usually provided in a skilled nursing facility.

(b) Extended Care Units

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefits may be provided for a longer period of time.

The Plan will not pay for services in an extended care unit unless, in the case of a Medicare patient, such extended care has prior approval of Medicare.

Exclusions:

1. Services, drugs or other items which are not covered for hospital inpatients;
2. Custodial care.

Positions of the Parties

Employee: The insurance carrier is responsible for payment of these charges, because the doctor requested that the patient be placed in a skilled nursing facility. In the past the carrier covered these charges.

Employer: The Employer ia not responsible for payment of the charges incurred in the skilled nursing facility from December 1, 1980 through June 17, 1981 because the confinement was "custodial care," which is specifically excluded under Article III, Section A (5) of the Benefit Plan.

Discussion

Under Article III, A (5) of the Employer's Plan, benefits are provided for skilled nursing care only if the patient's attending physician determines that skilled nursing care is medically necessary and if the level of care received by the patient is skilled. Benefits for custodial care are specifically excluded.

In this case, the patient's attending physician has stated that the patient received "intermediate custodial care." The UMWA Health and Retirement Funds' medical consultant concurs with the physician's opinion and has stated that the evidence is insufficient to justify payment of benefits for skilled nursing care. Therefore, under the requirements of Article III A (5), the patient would not qualify for skilled nursing care benefits.

Opinion of the Trustees

The Trustees are of the opinion that the Employer is not required to pay for the services received by the Employee's wife from December 1, 1980 through June 17, 1981, because they do not constitute skilled nursing care.