OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 84-280 - July 8, 1987

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 ("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 level of health benefits provided for physician services under the terms of the Employer Benefit Plan.

Background Facts

The Employee incurred various medical expenses for services from a provider on May 30, 1986. The Employer provided benefits for all the charges excluding one fee for diagnostic x-rays and laboratory services. The Employer requested additional information from the provider on several occasions in order to determine if the denied services were medically necessary, but the provider failed to supply the Employer with the requested information necessary to administer its Employer Benefit Plan. The Employee has requested the Employer to pay the outstanding medical bill.

Dispute

Is the Employer responsible for payment of benefits when the provider has failed to supply documentation to establish the medical necessity of the services?

Positions of the Parties

Position of the Employee: The Employer is responsible for paying benefits to the provider for medical services rendered to the Employee.

Position of the Employer: The Employer is not responsible for paying benefits to the provider because the provider has failed to supply the Employer with the necessary information to satisfy the reasonable and customary guidelines and medical necessity provisions of the Employer Benefit Plan.

Pertinent Provisions

The Introduction to Article III Benefits states:

> 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 Ill.

Article Ill. A. (3)(o) of the Employer Benefit Plan states in part:

> (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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> 3. Benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

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

> (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.

Article III. A. (10)(g) 2. states:

> 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 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. The Plan Administrator or his agent shall have sole control over the conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

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

> In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:
>
> 12. Excessive charges.

Discussion

The Plan Administrator and the insurance carrier have applied their previously implemented hold harmless procedures. Charges amounting to $115.00 are still disputed after several attempts to resolve the issues with the provider. These charges were incurred on May 30, 1986 as part of an office visit for which charges of $365.00 were initially submitted. The diagnoses stated on the invoice include thyroid dysfunction, musculoskeletal pain, dyspnea with chest discomfort and menopausal syndrome. The medical necessity is not established for $70 worth of injections normally associated with immunization. It is also not clear whether a pelvic exam and sigmoidoscopy, for which there was a charge of $45, are medically necessary. These tests are covered under the Plan only when medically necessary as described in Article III A. (3)(o) 2. and 3. The Plan Administrator requested additional information from the provider concerning charges for the injections, and the pelvic exam and sigmoidoscopy. When justification was not forthcoming after a period of five months, the charges were denied as not medically necessary.

The basic issue in this case is whether sufficient medical information was submitted to the Employer to enable the Employer to make a medical necessity determination provided for by the Plan. The Employer requested additional information from the provider on several occasions, but the provider failed to submit the requested documentation. A Funds' medical consultant has reviewed the charges as submitted and advises that they are not sufficiently documented to establish their medical necessity.

Article III. defines covered services as those 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, and Article III. A. (11)(a) 12. excludes excessive charges from coverage under the Employer Benefit Plan. Due to the lack of documentation to support the medical necessity and reasonableness of the medical services and charges in question, the Employer's denial of these charges is reasonable under the provisions of the Employer Benefit Plan.

Opinion of the Trustees

The Employer is not responsible for paying the provider for those medical services and charges for which the provider has failed to supply to the Employer the information necessary to determine whether the charges are covered under the Employer Benefit Plan. The Employer shall continue to hold the Employee harmless while the dispute exists with the provider.