OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 88-411 - February 26, 1992

Board of Trustees: Joseph P. Connors, Sr., Chairman; Paul R. Dean, Trustee; William Miller, Trustee; Donald E. Pierce, Jr., Trustee; Thomas H. Saggau, 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 implementation of a prescription drug utilization review program under the terms of the Employer Benefit Plan.

## Background Facts

The Employer has implemented a "Drug Overutilization" program to identify possible problems of excessive and potentially dangerous usage of prescription drugs and to reduce the costs associated with unnecessary drug usage. According to the information submitted by the Employer, whenever a possible problem is Identified, the claims administrator investigates by contacting the pharmacy(ies) and the prescribing physician(s) involved to determine whether the patient's condition warrants the current pattern of drug usage.

If drug overutilization continues despite peer-to-peer intervention with the prescribing physician(s), all medical facts, statements and documentation surrounding the drug usage are reviewed by three physicians who decide if further intervention is necessary. If all three reviewers agree that there is a clear, substantiated pattern of continued overutilization and immediate intervention is required, the following steps are taken:

(1) The patient (and also the employee/retiree if the patient is a dependent) is notified of the overutilization findings usually in a meeting with the Employer's Human Resources representatives and medical staff. The patient is asked to select one primary care physician and/or one pharmacy to coordinate their prescription drug needs.

(2) The patient is advised that continued use of multiple physicians and/or pharmacies, without the knowledge and approval of the selected primary care doctor, may result in expenses that may be deemed medically unnecessary and not payable under the Benefit Plan.

(3) The claims administrator continues to monitor the patient's medical care and drug usage. Prescriptions and other medical expenses that are not documented as necessary for the treatment of an illness or injury are denied in accordance with Benefit Plan limitations.

In a meeting with the Employee on August 29, 1990, a representative of the Employer's Plan Administrator and a member of the Employer's medical staff discussed the Employee's apparently excessive and potentially dangerous usage of prescription drugs and the benefits of using a primary care physician to coordinate his medical treatment and prescriptions. As a follow-up to the meeting, the Employer notified the Employee by letter dated September 14, 1990 that he was to use one primary care physician and to have all prescriptions filled at either of two selected pharmacies. The letter also stated, "should you decide to use any other physician or pharmacy, you will be responsible for any charges incurred." The Employer also notified the claims administrator of this arrangement in a memorandum dated September 21, 1990. The memorandum states that drugs would be covered only if prescribed by the primary care physician and that services rendered by any other provider after September 14, 1990 should be disallowed.

The Employee contends that the Employer does not have the right to restrict him to one physician and two pharmacies and that he should not be denied benefits if he chooses to use any other physician or pharmacy.

## Dispute

Is the drug utilization review program implemented by the Employer consistent with the provisions of the Employer Benefit Plan?

## Positions of the Parties

Position of the Employee: The Employer's program is in violation of the terms of the Employer Benefit Plan because the Employee's choice of providers is restricted to one physician and two pharmacies and the Employee is liable for charges for drugs prescribed by or incurred with any other provider. The Employee also contends that the designated primary care physician's office is not conveniently located and does not offer the specialized treatment he may require.

Position of the Employer: The Employer contends that its Drug Over-utilization program is consistent with the provisions of the Employer Benefit Plan. The Employer further contends that implementation of the program is within its authority under Article III. A. (10)(b) of the Plan to establish rules and regulations because the program is reasonable, clearly communicated, and does not reduce Plan benefits, but rather avoids medically unnecessary claims by coordinating treatment through a primary care physician. Moreover, the Employer maintains that the program "piggybacks" a cost containment program adopted by the Trustees under Article III. A. (10)(g).

Pertinent Provisions

The Introduction to Article III of the Employer Benefit Plan provides in pertinent part:

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.

Article III. A. (4) (a) of the Employer Benefit Plan provides in pertinent part:

> (4) Prescription Drugs
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> (a) Benefits Provided
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> Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in (3)(e).

Article III. A. (10) (b) and (g) of the Employer Benefit Plan provide in pertinent part:

> (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.
>
> (g) Explanation of Benefits (EOB), Cost Containment and Hold Harmless
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> 2. (i) Regarding health care cost containment, designed to control health care costs and to improve the quality of care without any reduction of plan coverage or benefits, the Trustees of the UMWA Health and Retirement Funds are authorized to establish programs of optional in-patient hospital pre-admission and length of stay review, optional second surgical

opinions, and case management and quality care programs and are to establish industry-wide reasonable and customary schedules for reimbursement of medical services at the 85th percentile (except when actual charges are less), and other cost containment programs that result in no loss or reduction of benefits to participants. The Trustees are authorized to take steps to contain prescription drug costs, including but not limited to, paying only the current average wholesale price, encouraging the use of generic drugs instead of brand name drugs where medically appropriate, and encouraging the use of mail order drug programs when advantageous.

(ii) The Trustees shall make available to the Plan Administrator any special cost containment arrangements that they make with outside vendors and/or providers. Further, the Plan Administrator may "piggyback" the cost containment programs adopted by the Trustees.

(iii) Disputes shall continue to be resolved in accordance with Article XX (e)(6) of the Wage Agreement.

(iv) It is expressly understood that nothing contained in this Section shall diminish or alter any rights currently held by the Employer in the administration of this Plan.

(v) Consistent with Article XX (12) of the 1984 and 1988 Wage Agreements, this Section in no way authorizes or implies a reduction of benefits or additional costs for covered services provided or relieves the Employer of any obligation set forth in Article XX of the Wage Agreement.

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Discussion

Article III. A. (4) (a) of the Employer Benefit Plan provides benefits for prescription drugs prescribed by a physician for treatment or control of an illness or a non-occupational accident or by a licensed dentist for treatment following the performance of Plan-covered oral surgical

services. The Introduction to Article III of the Plan states that covered services are limited to those which are medically reasonable and necessary and which are given at the appropriate level of care.

Under Article III. A. (10)(g) 2., the Trustees are authorized to establish health care cost containment programs designed to control health care costs and to improve the quality of care without any reduction of plan coverage or benefits. Article III. A. (10)(g) 2. further provides that Plan Administrators may "piggyback" the cost containment programs adopted by the Trustees.

In addition, under Article III. A. (10) (b), the Plan Administrator is authorized to promulgate rules and regulations to implement and administer the Plan. The Trustees have established in prior RODs that such rules and regulations are binding if they are reasonable and have been effectively communicated to the beneficiaries involved. See RODs 81-697, 84-042, 88-322 and 88-403.

The drug utilization review program implemented by the Employer in this case is intended to identify and reduce possible health risks associated with drug overutilization or adverse drug interactions and to eliminate the cost of unnecessary drugs. When potential drug overutilization problems are identified, the program includes specific procedures (i.e., contacts with the prescribing physician(s) and pharmacy(ies) involved and three independent medical reviews) to determine if and when further intervention is appropriate. Such procedures ensure that attempts are not made to limit a beneficiary's choice of providers unless there is a clear, substantiated pattern of continued overutilization. When such patterns are identified, it is reasonable for the Employer to meet with the beneficiary and request that he/she agree to choose one physician and one pharmacy to coordinate his/her prescription drug needs in order to avoid potentially dangerous and medically unnecessary prescription drug claims. The Employer has stated in response to this ROD that even when a beneficiary has chosen a primary care physician and one pharmacy, claims from other physicians or pharmacies will not be denied arbitrarily, but will be reviewed for medical necessity and paid if medically appropriate.

While the general aim of ensuring the medical necessity of prescription drug claims is reasonable and consistent with the provisions of the Employer Benefit Plan, the letter issued to the Employee in this case and the internal memorandum from the Employer's claims administrator clearly indicate that claims from any physician or pharmacy other than those agreed upon would be denied outright and the Employee would be liable for the charges incurred. There is no provision in the Employer Benefit Plan for claims to be denied solely on the basis of whether a particular provider is used.

Consequently, the Employer may not deny claims solely on that basis, but may deny claims for prescription drugs obtained without appropriate medical justification which supports their medical necessity.

The Trustees conclude that while the design of Employer's drug utilization review program as described in response to this ROD is a reasonable attempt to prevent potentially harmful and medically unnecessary prescription drug claims, the manner in which it was implemented and communicated to the Employee in this case, was in contravention to terms of the Benefit plan which generally permit employees freedom of choice in selection of providers.

## Opinion of the Trustees

The drug utilization review program established by the Employer is consistent with the medical necessity and cost containment provisions of the Employer Benefit Plan. However, for the

reasons stated above, the particular action taken by the Employer in this case did not comply with the Plan.