OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 98-049 – April 14, 2005

Trustees: Micheal W. Buckner, A. Frank Dunham, Michael H. Holland, and Elliot A. Segal.

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's daughter, whose date of birth is December 10, 1992, was involved in an automobile accident on May 31, 2001, which rendered her a quadriplegic. According to the Complainant, the only movement his daughter can make is to shrug her shoulders.

Upon his daughter's release from the hospital on October 10, 2001, the Complainant had installed at his home an overhead transfer device to assist the Complainant in lifting his daughter onto the toilet, into the bath, and onto her bed. On that same date, the Complainant also contracted to have a wheelchair lift installed to transport his daughter from the ground floor to the family's living quarters located on the second floor of a garage apartment.

According to documentation in the file, on August 4, 2001, the Complainant received estimates for installing the wheelchair elevator lift and overhead transfer device from a Durable Medical Equipment (DME) provider who was a participating provider in the BlueCross BlueShield of Alabama (BCBS of Alabama) network. The Complainant states that he then contacted HighMark to ask whether the items would be covered under his Employer's Benefit Plan. The Complainant states that after speaking with a HighMark representative on approximately six occasions over an approximate four-week period, the Complainant had the items installed. According to the Complainant, the representative kept telling him that the case was either being processed or that additional information was needed.

The Complainant claims that a representative of HighMark Blue Cross Blue Shield (HighMark), the Respondent's insurance carrier, led the Complainant to believe that the overhead transfer device and wheelchair lift would be covered supplies. However, the Complainant states that he cannot claim that the representative specifically told him that the supplies were covered benefits prior to the invoice dates of October 10, 2001.

The Complainant submitted copies of invoices for both items dated October 10, 2001, which he faxed to HighMark. By letter dated December 10, 2001, the DME provider sent invoice copies to BCBS of Alabama per HighMarks' request.

According to the Complainant's notes of a telephone conversation on January 16, 2002, with the HighMark representative, the representative stated that the claim "should be finalized in 1 to 2 days and check mailed to [DME provider]." On February 26, 2002, the Complainant's auto insurance paid $2,000, which was the maximum payment allowed under his insurance policy. On May 1, 2002, the Complainant noted that "Talked with [representative] on May 1st still processing" claims.

The Complainant states that after speaking with the representative on numerous occasions, he asked to speak with the representative's supervisor. The supervisor told him that the claim for the items had not been submitted to the correct claims reviewer, that she would file the claim with the correct reviewer, and that the items were most likely not covered under his medical plan. On May 31, 2002, according to his notes, the Complainant spoke with the supervisor and noted, "She stated that it [the claim] was in the system which is more than last time we spoke."

By letter dated July 29, 2002, HighMark requested information from the DME provider to assign the provider a DME identification number. An Explanation of Benefits (EOB) dated August 24, 2002, from HighMark stated that additional information was needed to review the claim. By letter dated September 3, 2002, from HighMark, the Complainant was notified that the claim for the wheelchair lift and overhead transfer device was denied.

Dispute

Is the Respondent required to provide coverage for the wheelchair elevator lift and overhead transfer device under the Employer Benefit Plan?

Positions of the Parties

Position of the Complainant: The Respondent is required to provide coverage for the wheelchair elevator lift and the transfer device under the Employer Benefit Plan because both items are medically necessary to assist the Complainant's daughter with safe mobility within her home. Furthermore, the Complainant asserts that the Respondent's insurance carrier led the Complainant to believe that the wheelchair elevator lift and transfer device were covered supplies.

Position of the Respondent: The Respondent is not required to provide coverage for the wheelchair elevator lift or the overhead transfer device because they are not medically necessary, as required by the Employer Benefit Plan, and both items could be useful in the absence of an illness or injury. The Respondent states that its position is supported by the Trustees' decisions

in RODs 88-624 and 233.

Pertinent Provisions

Article III A. (6)(d) of the Employer Benefit Plan states:

Article III Benefits

A. Health Benefits

(6) Home Health Services & Equipment

(d) Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

Q&A #81-38 states in pertinent part:

Subject: Medical Equipment and Supplies

References: Amended 1950 & 1974 Benefit Plans & Trusts,
Article III, Sections A (6) (d) and (e), and (7) (a) and (d)

Question:

What medical equipment and supplies are covered under the Plan?

Answer:

A. Under the Home Health Services and Equipment provision, benefits are provided for the rental and, where appropriate as determined by the Plan Administrator, purchase of medical equipment and supplies (including items essential to the effective use of the equipment) suitable for home use when determined to be medically necessary by a physician. These supplies and equipment include, but are not limited to the following:

1. Durable Medical Equipment (DME) which (a) can withstand use (i.e., could normally be rented), (b) is primarily and customarily used to service a medical

purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home. Examples of covered DME items are canes, commodes and other safety bathroom equipment, home dialysis equipment, hospital beds and mattresses, iron lungs, orthopedic frames and traction devices, oxygen tents, patient lifts, respirators, vaporizers, walkers and wheel chairs.

Article III A. (10) (e) of the Employer Benefit Plan provides:

ARTICLE III BENEFITS

A. Health Benefits

(10) General Provisions

(e) Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions 1 and 2 immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan and only upon receipt of an appropriate indemnification or subrogation agreement; but the primary and ultimate responsibility for payment shall remain with the other party or carrier.

Obligations to pay benefits on behalf of any beneficiary shall be conditioned:

1. upon such Beneficiary taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore, and

2. upon such beneficiary executing such documents as are reasonably required by the Plan Administrator, including, but not limited to, an assignment of rights to receive such third party payments, in order to protect and perfect the Plan's right to reimbursement from any such third party.

Discussion

Article III A. (6)(d) of the Employer Benefit Plan provides benefits for medical equipment suitable for home use when determined to be medically necessary by a physician. Q&A 81-38 states that covered equipment includes the following: "Durable Medical Equipment (DME) which (a) can withstand use (i.e., could normally be rented), (b) is primarily and customarily used to service a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home." Although an item of DME may meet the criteria outlined in Q&A 81-38, it is covered under Article III. A. (6)(d) of the Employer Benefit Plan only if it is medically necessary for the treatment of an illness or injury.

The Funds' Medical Director has reviewed this case, including letters from the Complainant's daughter's physician and physical therapist. According to the Medical Director, the overhead transfer device meets the requirements under Article III A. (6)(d) of the Employer Benefit Plan. However, the Medical Director found that the wheelchair elevator lift would not be covered under Article III A. (6)(d) because the equipment could be useful to a person in the absence of an illness or injury. This position is supported by ROD 78-233 where the Trustees found that the elevator lift "is not primarily and customarily used to serve a medical purpose. Additionally, such an item would generally be useful in the absence of an illness or injury."

The Respondent cited RODs 88-624 and 78-233 to support its position in this case. In ROD 88-624, the Trustees found that the Employer was not required to provide coverage for an oral surgery procedure under the Employer Benefit Plan because the surgery was not among the limited oral surgical procedures covered under the Plan, and the surgery was not medically necessary as part of the treatment for an illness or injury otherwise covered under the Plan. ROD 78-233, which was addressed above, is more analogous to the circumstances in the present case.

The Complainant claims that the Respondent should provide coverage for the wheelchair elevator lift too because a representative for the Respondent's insurance carrier led the Complainant to believe that it was a covered item. To support this claim, the Complainant submitted documentation, including fax cover sheets with notes taken during telephone conversations with the representative. On October 11, 2001, the Complainant sent a fax to HighMark with copies of the invoices dated October 10, 2001, for both the wheelchair lift and transfer device. On January 16, 2002, the Complainant spoke with a HighMark representative and noted the following: "should be finalized in 1 to 2 days and check mailed to [DME provider]." The Complainant's notes state that on March 28, 2002, "started processing" and that on May 1, 2002, the claim was being processed. Another note dated May 31, 2002, indicates that the Complainant spoke with the representative's supervisor, who stated that the claim "was in the system which was more than last time we spoke."

In ROD 81-655, the Trustees reviewed a case that questioned whether prior authorization had been provided for oral surgery, which was not covered under the Plan. The Trustees found that

"[u]nder usual circumstances, the Employer would thus not be required to provide coverage for this surgery. However, because the Complainant requested and received prior written assurances of coverage for these procedures from the Employer's insurance carrier, the Trustees have determined that the Employer should be responsible for the charges relating to these procedures."

A review of the documentation shows that while the Complainant had multiple contacts with a HighMark representative, he did not receive prior assurances, written or otherwise. The Complainant's note of the January 16, 2002, conversation which referred to mailing a check to the DME provider was after the October 10, 2001, invoice date for the overhead transfer device and wheelchair lift. There are no notes or other documentation dated prior to October 10, 2001, to indicate that the Respondent's insurance carrier informed the Complainant that the wheelchair lift and overhead transfer device were covered supplies. Moreover, the Complainant states that he cannot claim that a representative told him that the supplies were covered prior to the invoice date of October 10, 2001.

Under Article III A. (10) (e) of the Employer Benefit Plan, the Plan does not assume primary responsibility for covered medical expenses that another party is obligated to pay or which another insurance policy or other medical plan covers. In ROD 84-252, the Trustees found that the Employer was responsible for payment of covered medical expenses related to an auto accident "to the extent that benefits were not available under the Complainant's auto insurance policy to pay these expenses." According to the Complainant's auto insurer, the maximum amount of $2,000 for covered medical expenses has been paid for the May 31, 2001, accident. Therefore, the Respondent is required to provide coverage for the remaining costs of covered medical services related to the accident, which would include the medically necessary overhead transfer device.

Opinion of the Trustees

The Respondent is required to provide coverage for the overhead transfer device under Article III A. (6) (d) the Employer Benefit Plan. The Respondent is not required to provide coverage for the wheelchair lift.