OPINION OF TRUSTEES

In Re

Complainant: Pensioner
Respondent: Employer
ROD Case No: CA-058 – 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 Coal Industry Retiree Benefit Act of 1992 (Coal Act) Employer Benefit Plan maintained pursuant to section 9711 of the Internal Revenue Code.

Background Facts

The Complainant, who is bedridden, lives with his daughter and her husband. Since 1996, due to multiple medical problems, the Complainant's physician has ordered that home health care services be provided through a home health care agency for the Complainant. The home health agency provided the following services for the Complainant: monthly blood work and weekly assistance with bathing and grooming.

Prior to February 5, 1998, if a patient required venipuncture (drawing of blood), which was considered a skilled service by Medicare, coverage for supportive services such as home health aides was also covered by Medicare. Consequently, the services that the Complainant received from the home health agency prior to February 5, 1998, were covered by Medicare. However, due to a change in Medicare policy, effective February 5, 1998, venipuncture no longer qualified as a skilled service. Therefore, effective February 5, 1998, a patient who had previously received coverage for home health aide services based solely on venipuncture, no longer qualified for these services.

As a result of changes in Medicare policy, on February 5, 1998, the home health care agency contacted the Respondent to inquire as to whether the services previously covered by Medicare would be covered under the Respondent's Employer Benefit Plan. According to the form completed by the home health agency representative who spoke with the Respondent's insurance carrier, no deduction, pre-authorization, or monthly telephone call would be required for the services discussed. The form also indicated that there was no limit on visits per calendar year and the claims would be paid at 100%. The agency representative noted that itemized billing was to accompany the home health nursing notes.

Effective February 10, 1998, the home health care agency continued to provide to the Complainant the same services that had previously been covered by Medicare. By letter dated

February 23, 1998, the home health care agency notified the Complainant that per the Complainant's request, billing for the home health agency charges had been switched from Medicare to the Complainant's private insurance (the Respondent). According to the Respondent's insurance carrier, the charges for February were received in April 1998 and the charges for March and April were received in July 1998. The notation on the Explanation of Benefit (EOB) statements from the Respondent's insurance carrier for those months indicates that no charges were paid but that the charges would be reconsidered upon receipt of a Medicare review.

Under the Employer Benefit Plan, custodial care constitutes services that assist an individual to meet the activities of daily living. The Complainant's daughter stated that in January 1999 she received an EOB statement from the Respondent's insurance carrier indicating that the care provided by the home health care agency was denied because it was custodial and therefore not a covered service. Upon receipt of this statement, the Complainant's daughter contacted the home health agency on January 29, 1999, to request that the custodial care be terminated, and such coverage was terminated on that date.

The Respondent has denied coverage for the custodial services provided to the Complainant from February 10, 1998, through January 29, 1999.

Although Funds' staff requested copies of the home health care notes for the period in dispute, only notes for October 1998 through January 29, 1999, were submitted.

Dispute

Is the Respondent required to provide coverage for the care provided to the Complainant by the home health service agency?

Positions of the Parties

Position of the Complainant: The Respondent is required to provide coverage for the services provided by the home health care agency because the services were approved by the Respondent.

Position of the Respondent: The Respondent is not required to provide coverage for the services provided by the home health care agency because of the following: 1) custodial care is expressly excluded under the Employer Benefit Plan; 2) only home health services were authorized, and those charges were paid for; and 3) the specific type of home health service that was to be provided by the agency was not discussed by either the agency or the insurance carrier.

Pertinent Provisions

Article III. A. (6) (a), b, and (c) of the Employer Benefit Plan states:

Article III Benefits

A. Health Benefits

(6) Home Health Services & Equipment

(a) General Provisions

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Plan Administrator.

1. The Beneficiary must be under the care of a physician.

2. The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

3. The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

4. The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

(b) Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c) Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Plan Administrator may request an evaluation visit to the Beneficiary's home.

* * *

Article III. A. (11) (a) 8. of the Employer Benefit Plan states:

Article III A. (11) (a) 8. provides:

Article III Benefits

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:

* * *

8. Custodial care, convalescent or rest cures.

Discussion

Article III. A. (6) of the Employer Benefit Plan provides that benefits for home health services, including visits by registered nurses and home health aides, are provided under certain circumstances. Benefits are provided, for example, to a Beneficiary whose medical condition requires skilled nursing care, physical therapy or speech therapy at least once in a 60-day period. Benefits for custodial care, however, are specifically excluded under Article III. A. (11) (a) 8. of the Employer Benefit Plan.

Skilled nursing care is generally considered to encompass those services that are reasonable and necessary for the treatment of an illness or injury. Skilled nursing care must be performed by or under the direct supervision of a licensed nurse if the safety of the patient is to be assured and the medically desired result is to be achieved. Custodial care is a lower level of care and constitutes services that assist an individual to meet the activities of daily living (i.e. personal care, feeding, and toileting). The Funds' Medical Director has reviewed the evidence submitted in this case and has determined that the care delivered was custodial in nature.

According to the Complainant, prior approval was given by the Respondent's insurance carrier to the home health agency for the care provided. While the Respondent acknowledges that its insurance carrier approved coverage for home health services, the Respondent denies that it provided approval for custodial care because custodial care is not covered under the Employer Benefit Plan. A review of the form completed by the home health agency representative who spoke with the Respondent's insurance carrier concerning the coverage in question makes no reference to custodial care. In fact, the only reference with regard to the type of care discussed is that the home health agency had to provide a copy of its nursing notes which described the care provided.

In ROD 81-655, the Trustees reviewed a case in which the question was raised as to whether prior authorization for coverage had been provided for a service that is not covered under the Plan. The Complainant in ROD 81-655 underwent oral surgery, a non-covered benefit. The Trustees found that "Under 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."

In the present case, the Funds' Medical Director has determined that the services provided by the home health agency for the period of October 1998 through January 1999, the only period for which treatment records were provided, were custodial in nature. Under usual circumstances, the Employer would not be required to provide coverage for these services. Records of the home health agency and the insurance carrier reflect, however, that the home health agency was

informed by the insurance carrier in February 1998 that home health services are a covered

benefit under the Employer Plan, that there was no deductible, that prior authorization was not required and that the home health agency would only be required to submit its nursing notes and itemized bills to the insurance carrier. There is no evidence that a treatment plan specific to the type or level of care that would be provided to the Complainant was discussed between the insurance carrier and the home health agency at any time. Based on the February 1998 telephone call, the home health agency continued to provide services to the Complainant. Subsequently, the insurance carrier denied a number of claims submitted by the home health agency pending receipt of a medical review. Based on the documentation in the file, the insurance carrier did not deny any of the claims submitted by the home health agency on the basis that the care was custodial during the period of February 1998 through January 1999 until December 1999. When the Complainant's daughter learned in January 1999, however, that the home health agency's services were considered to be custodial in nature, the home health agency's services were immediately terminated.

Opinion of the Trustees

Considering all the facts in this dispute, the Trustees are of the opinion that the Respondent is responsible for payment of the charges incurred by the Complainant for the home health services provided to the Complainant during the period of February 10, 1998, through January 29, 1999.