BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between DOUGLAS COUNTY PROFESSIONAL HUMAN SERVICES EMPLOYEES LOCAL UNION NO. 2375, AFSCME, AFL-CIO and DOUGLAS COUNTY (HUMAN SERVICES)	Case 227 No. 54305 MA-9619

Appearances:

Mr. James E. Mattson, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, appearing on behalf of the Union.

Ms. Candace Fitzgerald, Personnel Director, Douglas County, appearing on behalf of the County.

ARBITRATION AWARD

Pursuant to a request by Douglas County Professional Human Services Employees Local Union No. 2375, AFSCME, AFL-CIO, herein the Union, and the subsequent concurrence by Douglas County (Human Services), herein the County or Employer, the undersigned was appointed arbitrator by the Wisconsin Employment Relations Commission on August 28, 1996, pursuant to the procedure contained in the grievance-arbitration provisions of the parties' collective bargaining agreement, to hear and decide a dispute as specified below. A hearing was conducted by the undersigned on October 31, 1996, at Superior, Wisconsin. The hearing was not transcribed. The parties completed their briefing schedule on December 19, 1996.

After considering the entire record, I issue the following decision and Award.

ISSUES:

The parties were unable to stipulate to the issues. The Union frames the issues as follows:

> Did the Employer violate the terms of the Collective Bargaining Agreement and past practice when the Grievant was denied payment for physical therapy expenses by the County's health insurance provider?

> And if so; the appropriate remedy is for the Employer to pay the Grievant for these unpaid medical expenses.

The Employer frames the issue as follows:

> Did the County violate Article 9, Section 4 of the union contract when the insurance company denied the grievant's physical therapy claims based on medical necessity.

Based on the entire record, the Arbitrator frames the issues in the following manner:

> Did the Employer violate Article 9, Section 4 of the collective bargaining agreement when the Grievant was denied payment for physical therapy expenses by the County's health insurance provider?
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> If so, what is the appropriate remedy?

DISCUSSION:

Mary Paquette, hereinafter the Grievant, has been an employe of the County for over 15 years. In November of 1992, she suffered back injuries in an automobile accident. After this accident, she received physical therapy treatments for several years. Her health insurance provider paid for these treatments.

On March 11, 1996, the Grievant received her explanation of benefits statement from the Epic Life Insurance Company denying payment of physical therapy expenses in the amount of $567.00 covering the period from May 31, 1995 to July 3, 1995. Epic stated these charges were not covered because the treatment was not considered a medical necessity.

On March 29, 1996, the Grievant wrote a letter to her treating physician Dr. Martinson requesting that he write a letter to Epic explaining the necessity of continuing extended physical therapy treatments.

Shortly thereafter, the Grievant wrote an appeal letter to Epic, attaching a letter from Dr. Martinson, stating that in his opinion the physical therapy treatment prescribed after March 29, 1995, was medically necessary and asking the insurance company to reconsider their

decision to deny payment.

On May 2, 1996, Epic responded to the Grievant's appeal letter explaining that a peer level review by their medical consultants determined that the documentation provided did not support continued physical therapy in treatment of her condition beyond May 31, 1995. Epic explained that the Grievant's condition did not meet the following criteria:

> According to page 11, Section 3(a), of your Certificate of Insurance: benefits are payable for outpatient physical, speech, occupational, and respiratory therapy up to a combined total of 15 sessions per illness or injury. Benefits are payable for additional sessions only to the extent the Claim Administrator approves such additional therapy as being appropriate for a participant's medical condition.

On May 22, 1996, John Mulder, Personnel Director for the Employer, sent a memo to Union President, Jim Borgeson, stating that he reviewed the 1986 Blue Cross/Blue Shield Health Insurance document compared to Epic's document and did not find a difference in the level of coverage, based on the criterion of medical necessity.

On May 29, 1996, the Grievant filed a grievance stating the Employer violated Article 9, Section 4 of the agreement by its action and requesting a remedy of payment of an outstanding bill in the amount of $567 and any on-going related expenses.

On July 2, 1996, the Employer sent a memo to the aforesaid Union president, denying the grievance and attaching a letter from Epic dated June 28, 1996, outlining the factors involved in their decision to deny physical therapy benefits for the Grievant beyond May 31, 1995, based on medical necessity.

Thereafter, on July 22, 1996, the Union requested arbitration of the aforesaid dispute by a staff arbitrator appointed by the Wisconsin Employment Relations Commission.

Article 9 entitled "Health and Welfare," Section 4 provides, in relevant part, as follows:

> County reserves the right to change the insurance carrier and/or self-fund its insurance program, provided the coverages are substantially equivalent or superior to the health insurance coverages that were offered by Blue Cross/Blue Shield in 1986.

The Union argues that the Employer violated the above contract provision when it denied the Grievant's claim while the Employer takes the opposite position.

The resolution of this dispute turns on the meaning of the phrase ". . . provided the coverages are substantially equivalent or superior to the health insurance coverages that were offered by Blue Cross/Blue Shield in 1986." No evidence of bargaining history leading to the inclusion of this language in the parties' collective bargaining agreement was introduced. Therefore, absent a showing that some special meaning should attach to the words contained in that phrase, the plain meaning of the term must be applied.

The American Heritage Dictionary, Second College Edition, 1985, defines "substantial" at page 1213 as "1. Of, pertaining to, or having substance; material. 2. Not Imaginary; true; real." "Substance" is then defined as "2.a. Essential nature; essence. b. Gist; heart."

"Substantially" as it is used in Article 9 modifies the word "equivalent," and the two words used together modify "health insurance coverages"; in other words, in substance meaning the same level of health insurance coverage.

A conclusion that by agreeing to the aforesaid contract language, the Employer agreed whenever changing the insurance carrier (or self-funding its insurance program) that it would provide the same level of benefits or health insurance coverage is supported by the dictionary definition of the word "same." (Emphasis added) "Same" is defined in The American Heritage Dictionary, Second College Edition, supra, at page 1088, as follows:

> 1. Being the very one; identical. 2. Similar in kind, quality, quantity, or degree. 3. Conforming in every detail; according to the same rules as before. 4. Being the one previously mentioned or indicated; aforesaid.--adv. In the same way.--pron. 1. Someone or something identical with another. 2. Someone or something previously mentioned or described. . . .
>
> **Synonyms:** same, selfsame, identical, equal, equivalent. These adjectives refer to the absence of difference or disparity. (Emphasis added)

Such a conclusion is also supported by the inclusion of the phrase "or superior" in Article 9, Section 4. The inclusion of these two words, in the opinion of the Arbitrator, means that as long as the parties are subject to a collective bargaining agreement containing the aforesaid contract clause the Employer agrees to maintain at least the same, if not better, level of insurance benefits or coverage no matter who the carrier. (Emphasis added)

It is the Employer's position, however, that the Epic insurance coverage currently provided is "substantially equivalent or superior to the health insurance coverage offered by Blue Cross and Blue Shield of 1986." The record, however, does not support a finding regarding same. To the contrary, the record is clear that Epic does not maintain the same level of benefits as the Employer's health insurance carrier in 1986. (Emphasis added) In this regard, the Arbitrator notes that the Union provided testimony by two witnesses, Union President Jim Borgeson and the Grievant, unrefuted by the Employer, 1/ that claims like the Grievant's have always been paid by the County since 1986, and that there have not been any claims like the Grievant's which have been denied at any time material herein. The Grievant also testified that she has made 111 visits to a physical therapist over the past four years since her accident, and over 100 were paid for with none being denied until Epic's turn down. Based on the foregoing, the Arbitrator finds that by denying the Grievant's claims for payment of physical therapist expenses Epic has not provided nearly the same "or superior" level of benefits or coverage as was provided under previous plans. As noted above, this violates the plain meaning of Article 9, Section 4 which requires same.

The Employer also argues that Epic has the right to determine "medical necessity," and to make decisions whether to pay claims independent of past practice and/or an employe's physician's determination of what constitutes "medical necessity." The Employer adds that it "will argue that because the grievant's physical therapy treatments were previously paid for, does not necessarily mean they will continue to be paid for . . ." absent a determination they are medically necessary. However, that is exactly the point. Contrary to the Employer's assertion, the aforesaid contract language requires that the Employer provide at least the same medical coverage now as it did in 1986. It is clear that prior insurance carriers paid the Grievant's claims and claims by other employes like hers. Therefore, since claims for such treatments were paid previously the Employer is contractually obligated to see that they are paid now independent of any determination as to their "medical necessity." Consequently, the Arbitrator does not have to reach the question of whether the Grievant's physical therapy sessions were "medically necessary," in order to decide the instant dispute.

In addition, the Employer argues:

> To make any decision outside the insurance plan, to pay outstanding medical bills, or approve continuation of coverage for medical treatments beyond what the insurance plan provides for, would erode the value of the health insurance plan. This would

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1/ The Employer's claim that in May of 1994, WPS paid some claims incorrectly does not, in the opinion of the Arbitrator, even if true, negate 15 years of past practice whereby the Employer's insurance carrier paid such claims.

> cause the County a great deal of concern because any individual who would receive treatment prescribed by their treating physician would assume that the coverage is medically necessary, regardless of whether or not it meets the criteria required by the plan document. (Emphasis added)

To the extent that the Employer must rectify its contract violation by immediately making the Grievant whole by paying her outstanding bill of $567 for physical therapy treatments and by paying any "ongoing related expenses," the Arbitrator would agree with the Employer that the "value" of the current health insurance plan may be eroded. However, this is an issue the Employer could remedy with Epic by having said carrier modify its plan to pay for physical therapy treatments as required by the Grievant so that its plan will provide employes with coverage which is "substantially equivalent or superior to the health insurance coverages that were offered by Blue Cross/Blue Shield in 1986." Failing this, the Employer could take steps to replace Epic or bargain over the level of health insurance coverage with the Union now or when the current contract expires. In the meantime, as noted in Article 1, "the intent and purpose of this Agreement" is "to set forth herein the basic agreement covering rates of pay, hours of work and conditions of employment to be observed between the parties." Employes, like the Grievant, are entitled to the protections contained in Article 9, Section 4 regarding the level of their health insurance coverage until the parties agree to something different.

The Employer is also concerned about employes believing that something is "medically necessary" if they receive treatment from their treating physician, and assuming it will be paid for despite whether or not it meets the plan criteria. However, as noted above, the issue before the Arbitrator is not whether something (i.e. a treatment) is medically necessary or whether it meets the criteria required by the current plan document; it is whether the medical treatment or service is covered by the parties' collective bargaining agreement. More particularly, it is whether the medical treatment or health care service provided is "substantially equivalent or superior to" the health insurance coverage offered by Blue Cross/Blue Shield in 1986. The Grievant herein has clearly met her burden of proving that the physical therapy treatments in question have been paid for by the Employer's health insurance provider since 1986. Other employes would have the same burden in a similar dispute with the Employer.

The Employer is further concerned that if the Grievant prevails "it would put the County in a position of making discriminatory decisions based upon emotions." However, as noted above, the process for deciding whether to pay claims like the Grievant's is really more objective than that suggested by the Employer. The standard is contained in Article 9, Section 4 and requires the Employer to provide coverages "substantially equivalent or superior to the health insurance coverages that were offered by Blue Cross/Blue Shield in 1986."

Finally, the Employer argues the fact that the Group Master Plan document and other

handbooks may not have been made available to employes does not mean "that the County's health insurance benefits are not substantially equivalent or superior to the health insurance coverage offered" in 1986. The Arbitrator agrees. However, based on all of the foregoing, and absent any persuasive evidence or argument to the contrary, the Arbitrator finds that by denying payment for the Grievant's physical therapy expenses the Employer failed to provide to the Grievant "substantially equivalent or superior" coverages as she enjoyed under the Blue Cross/Blue Shield plan in effect in 1986.

In view of all of the above, the Arbitrator finds that the answer to the issue as framed by the undersigned is YES, the Employer violated Article 9, Section 4 of the collective bargaining agreement when the Grievant was denied payment for physical therapy expenses by the County's health insurance provider, and it is my

AWARD

That the grievance filed in the instant matter on May 29, 1996, by Mary Paquette is hereby sustained, and the Employer is ordered to pay her $567 for physical therapy expenses owed the Polinsky Medical Center as well as reimburse her for any ongoing related expenses.

Dated at Madison, Wisconsin, this 18th day of February.

By Dennis P. McGilligan /s/
Dennis P. McGilligan, Arbitrator