BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

DOOR COUNTY COURTHOUSE EMPLOYEES, LOCAL #1658, AFSCME, AFL-CIO

and

DOOR COUNTY

Case 124
No. 58912
MA-11105

Insurance Coverage for Chiropractic Care

Appearances:

Mr. Grant Thomas, Door County Corporation Counsel, P.O. Box 670, Sturgeon Bay, Wisconsin 54307-3067, appearing on behalf of Door County.

Wisconsin Council 40, AFSCME, 8033 Excelsior Drive, Suite B, Madison, Wisconsin 53717-1903, by **Mr. James Miller** and **Mr. Michael Wilson**, Staff Representatives, appearing on behalf of Local 1658.

ARBITRATION AWARD

Pursuant to the provisions of the collective bargaining agreement between the parties, AFSCME Local 1658 (hereinafter referred to as the Union) and Door County (hereinafter referred to as the Employer or the County) requested that the Wisconsin Employment Relations Commission designate a member of its staff as arbitrator to hear and decide a dispute concerning the provision of chiropractic coverage for unit employees. The undersigned was so designated. A hearing was held on August 1, 2000, in Sturgeon Bay, Wisconsin, at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. The parties submitted post-hearing briefs, which were received on September 6, 2000, whereupon the record was closed.

Now, having considered the testimony, exhibits, other evidence, contract language, arguments of the parties and the record as a whole, the undersigned makes the following Award.

To maximize the ability of the parties we serve to utilize the Internet and computer software to research decisions and arbitration awards issued by the Commission and its staff, footnote text is found in the body of this decision.

ISSUES

The issues before the Arbitrator are:

1. Is the grievance substantively arbitrable? If so,

2. Did the Employer violate Article 18, Section F, of the collective bargaining agreement when the Third Party Administrator denied certain chiropractic claims submitted by Diane Christenson? If so,

3. What is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

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ARTICLE 4 - GRIEVANCE PROCEDURE

A. **Definition of Grievance:** The parties agree that the prompt and just settlement of grievances is of mutual interest and concern. Should a grievance arise, whether in reference to a question of interpretation of the Agreement or to a question relating to safety and/or other matters, the grieving employee shall first bring the complaint to the Steward or Grievance Committee of the Union.

B. **Grievance Procedure Steps:** If it is determined after investigation by the Union that a grievance does exist, it shall be processed in the manner described below.

Step 1: Grievances shall be stated in writing, a copy of written grievances shall be given to the Department Head and the Human Resources Director. The Steward shall meet with and attempt to resolve the grievance with the Department Head and Human Resources Director within thirty (30) days after the grievant knew or should have known of the cause of such complaint. The Department Head and the Human Resources Director shall answer the grievance in writing to the Union Steward within fifteen (15) days following notice of the existence of the grievance.

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Step 3: The grievance shall be submitted to arbitration by giving notice in writing to the Employer within thirty (30) days after the written reply of the Executive and Personnel Committee.

Thereafter and within the following ten (10) days, the Union and the Employer shall each select one (1) member of a three (3) member Arbitration Board. The two (2) members of the Arbitration Board shall select the third (3rd) member who shall serve as Chairperson. If the third (3rd) member of the Arbitration Board is not selected within ten (10) days following the notice of the arbitration, the WERC upon submission of standard request form(s), shall be authorized to appoint the Chairperson of the Arbitration Board from its staff.

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ARTICLE 18 - INSURANCE

A. **Health Insurance.** The Employer agrees to pay ninety percent (90%) of the premium costs of the employee's family plan hospitalization and medical benefits insurance program for employees with a spouse and/or dependents.

The Employer agrees to pay one hundred percent (100%), or all of the premium costs of the employee's single plan hospitalization and medical benefits insurance program for employees without a spouse or dependents.

Effective upon ratification by both parties, the Employer agrees to pay ninety percent (90%), of the premium costs of the employee's single plan hospitalization and medical benefits insurance program for employees without a spouse or dependents.

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D. **Change in Carrier:** Should there be any change in the insurance coverage or carrier, contemplated by the Employer, the Employer shall notify the Union and meet to resolve such problems as may arise.

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F. **Mandated Benefits:** The County will maintain all benefits that were covered by Blue Cross as of 1986.

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EXCERPTS FROM HEALTH INSURANCE PLAN DOCUMENTS

(Current)
HEALTH AND DENTAL PROTECTION PLANS
MASTER PLAN DOCUMENT FOR
EMPLOYEES OF DOOR COUNTY
M-337
(Herein Called The Plan)

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"**MEDICALLY NECESSARY"** means a service or supply is required to treat or diagnose an Injury or Sickness, and that it is:

1. consistent with and appropriate for the symptoms, diagnosis or treatment of the patient's condition;

2. of proven value or usefulness, is likely to yield further information, and is not redundant when done with other procedures.

3. the most appropriate means to safely care for the patient. If an In-patient, it also means that care can not safely be given on an out-patient basis;

4. not solely for the convenience of the patient, the patient's family or the provider.

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(1986)

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BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
GROUP CONTRACT

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DOOR COUNTY AND DOOR COUNTY HIGHWAY DEPARTMENT

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MEDICALLY NECESSARY (OR MEDICAL NECESSITY) - means that the services or supplies provided by a HOSPITAL, PHYSICIAN, or OTHER PROVIDER are required to diagnose or treat a MEMBER'S ILLNESS or

injury. The determination of whether a service or supply is medically necessary will be made by the PLAN based on the recommendations of its Health Policy Review Consultants and Advisors or the findings of a utilization review process that, according to generally accepted medical practice, the services or supply is:

1. consistent with and appropriate for the treatment or diagnosis of the MEMBER'S symptoms, ILLNESS or injury;

2. of proven value or usefulness, is likely to yield additional information, and is not redundant when performed with other procedures;

3. the most appropriate level of service or supply which can safely be provided to the MEMBER. When applied to the care of an INPATIENT, it further means that the MEMBER'S medical symptoms or condition require that the services cannot be safely provided to the MEMBER as an OUTPATIENT; and

4. not primarily for the convenience of the MEMBER, MEMBER'S family or the PROVIDER.

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BACKGROUND

The Employer provides general governmental services to the people of Door County, Wisconsin. The Union is the exclusive bargaining representative for many of the Employer's workers, including a bargaining unit of courthouse employees. The courthouse bargaining unit was organized in 1986. At the time that the initial collective bargaining agreement was being bargained, the Union was negotiating in another bargaining unit over a change from a Blue Cross health insurance plan to a self-funded plan. The negotiators for the courthouse unit agreed to insurance language continuing the benefits in effect under the Blue Cross Plan.

One of the benefits provided in the Blue Cross plan was chiropractic care and this was continued in the self-funded plan. Prior to 1999, there is no record of an employee having a claim for chiropractic services rejected by the County's third party administrator. The County's self-funded plan, like the Blue Cross plan, limits payment to those services that are medically necessary. In 1999 and 2000, several employees had claims rejected as not being medically necessary.

One of the employees who made claims for chiropractic services was Diane Christenson. Ms. Christenson works for the Department of Public Health and has been with the County for 23 years. She has seen a chiropractor off and on since 1995, owing to a variety of car accidents, falls and work related injuries. Until March of 2000, none of her claims were

denied. In March, the County's third party administrator, Employee Benefit Claims of Wisconsin ("EBC"), sent her chiropractor's records of the case to Dr. Dennis King, a chiropractor it contracted with to review issues of medical necessity. Dr. King determined that the documentation of her care did not suggest that further treatment would yield further improvement. Based on the records, he advised EBC that her treatments after December 16, 1999, were not medically necessary. EBC, thereafter, declined to pay Christenson's chiropractor. The chiropractor submitted additional documentation, showing that Christenson had fallen on ice in February of 2000, and EBC authorized some additional payments for treatments related to the falls, but still did not cover all of her visits. She has since paid for chiropractic services out of her own pocket.

Other employees had similar experiences in late 1999 and early 2000. Jeanne Kasten is another employee who had received chiropractic services. From 1986 through November of 1999, she had never had a claim denied. In November of 1999, she received a letter from EBC saying that her doctor had not provided sufficient information to justify the treatment as necessary and that they were denying payment. She contacted her doctor and he said he had supplied EBC with the information they requested, but she has since paid for the treatments herself. Steven Graf, a Bridge Operator for the County, was also advised in December of 1999 that Dr. King had determined that his chiropractic care was not medically necessary and payments were stopped.

Employee Christine Moe saw a chiropractor quite often in 1995. Towards the end of that year, EBC began denying her claims. According to Moe, she called EBC and was told that there was a cap of 20 visits per year on chiropractic treatment. Moe reviewed the minutes of the County Board for 1994 and 1995, but could find no reference to any cap on chiropractic visits having been adopted by the Board.

Additional facts, as necessary, are set forth below.

ARGUMENTS OF THE PARTIES

The Position of the Union

The Union takes the position that the contract clearly and unambiguously requires the County to provide, under its self-insurance plan, benefits equal to those that had been offered under the Blue Cross and Blue Shield plan in effect in 1986. Both plans contain essentially the same definition of medical necessity, and thus, the administration of both plans should yield identical treatment of identical claims. Here, however, it is apparent that the plan administrator has changed the treatment of chiropractic benefits. From 1986 through 1998, the evidence shows that no claim for chiropractic treatment was ever denied. Individuals were allowed to receive on-going regimens of chiropractic care, including Jeanne Kasten, who regularly and continuously received chiropractic care from 1986 to 1998, without any question being posed as to medical necessity. Beginning late in 1999, claims for chiropractic care,

including Kasten's, began being rejected as not medically necessary. Grievant Christenson suffered a legitimate injury and then aggravated that injury in a fall, yet the plan administrator seriously limited Christenson's access to her chiropractor. This is not merely a neutral application of the medical necessity language in the plan document. Instead, it represents a concerted effort by the County, through its agent, the plan administrator, to reduce the benefits available to employees under the insurance plan. Such an effort violates the contract and the Arbitrator must order the County to cease and desist from its new practice, restore the status quo and make the affected employees whole.

The Position of the Employer

The County takes the position that the grievance is beyond the authority of the Arbitrator and must be dismissed on jurisdictional grounds. Grievances enjoy a broad presumption of arbitrability, but that presumption is not unlimited. Here, the contract limits the Arbitrator to interpreting and applying the contract and does not permit additions, subtractions or modifications under the guise of interpretation. In the instant case, the Union is not contending that insurance benefits are not being provided, which is what the contract guarantees. Instead, it disputes the third party administrator's interpretation of the medical necessity language of the plan document. That document is not even arguably within the Arbitrator's purview. It contains its own protections and appeal procedures, none of which involve a grievance arbitrator. As there is no dispute under the labor agreement for the arbitrator to decide, the Arbitrator lacks subject matter jurisdiction.

Turning to the merits, the County asserts that the contract promises to continue the insurance benefits in effect as of 1986. The 1986 insurance plan excludes services that are not medically necessary. Likewise, the current insurance plan excludes any that are not medically necessary. The chiropractic services at issue here were denied because, after a medical review, they were determined not to be medically necessary. This case by case determination is something that is a feature of both insurance plans and since the plans are the same, there is no violation of the County's promise to maintain the same insurance benefits. Accordingly, the grievance should be denied.

DISCUSSION

Substantive Arbitrability

The question of whether a matter is subject to grievance arbitration goes to the jurisdiction of the Arbitrator and is a threshold issue that must be answered before any other aspect of the case may be addressed. The County asserts that the Union is seeking to have the Arbitrator make determinations of medical necessity, determinations that have no basis in the contract and which are reserved to the appeal procedures of the plan administrator.

Article 18 of the contract promises to provide health insurance and according to the witnesses in this case, Section F promises that the self-insured plan will maintain the level of benefits that were in effect under the 1986 Blue Cross indemnity plan. The Union's theory of this case is that the County, through its agent EBC, is reducing benefits for chiropractic care. In the simplest terms, the County used to treat all chiropractic treatments as medically necessary and reimbursable and it is no longer doing so in a deliberate effort to reduce benefits. The County views that as a misreading of the insurance plan, and it may be, but that does not render it non-arbitrable. Certainly, an arbitrator is not the proper venue for determining medical necessity in a given case. If the evidence shows, however, that the County's agent has adopted an overall policy of effectively reducing the employees' insurance benefits, that course of action implicates Section F of the contract and the mere use of the term "medical necessity" to justify the reduction does not prevent the Union from enforcing its right under Article 18. Regardless of the merits of the Union's position, its theory of the case raises a claim under the collective bargaining agreement, and I, therefore, conclude that the matter is substantively arbitrable.

The Merits of the Case

The issue on the merits of this case is whether the denial of chiropractic claims beginning in late 1999 represents a reduction in the employees' insurance benefits. The claims of Christenson, Kasten and Graf were denied because the reviewing doctor determined that their chiropractor's documentation did not prove that additional treatments were medically necessary. It appears that none of these employees' claims had ever been denied before late 1999.

Both the 1986 Blue Cross plan and the County's self-insurance plan exclude payment for services that are not medically necessary. There is no evidence in the record as to whether Blue Cross ever denied a chiropractic claim as medically unnecessary, but it clearly had the right to do so under the policy. 1/ The County has reserved that same right in its benefit plan, and has exercised it in these individual cases. The denials expressly rely on medical necessity. Medical necessity is a condition precedent to the payment of a claim under both plans. While the right to determine medical necessity may not have been invoked in the past, the decision to invoke it now cannot be accurately characterized as a change in benefits. It has always been a part of the benefit package.

1/ To the extent that the Union's theory is that challenging the medical necessity of treatments represents a change in practice, the lack of any evidence of Blue Cross's practice before 1986 is a fatal defect in the record. The right claimed by the Union is to receive the same benefits from EBC as were received from Blue Cross. Assuming solely for the sake of argument that a claim based on administrative practices rather than the written insurance plans themselves would have any validity, it requires a finding by the Arbitrator that Blue Cross waived its right to assert medical necessity as a pre-condition to receiving benefits, or at least never denied a claim based on medical necessity. In other words, in order to make out the case that EBC is doing something differently, the Union must provide evidence of what Blue Cross did with such claims.

The testimony of Christina Moe regarding the denial of her claims for chiropractic care in 1995 presents a different issue. According to Moe, she was told by EBC that the County would not pay for more that 20 visits to a chiropractor in any calendar year. A fixed cap on visits bears no relationship to the medical necessity of treatment for any individual patient and no plausible argument could be made that a cap is not a unilateral reduction in benefits. However, the contract requires that grievances be submitted within 30 days of the date on which the violation was known to the grievant and the time has long since passed for Moe to challenge the 1995 denial of her claims. There was no reference to a cap of any type in the denials in 1999 and 2000, and the denial of Christenson's claims was plainly not caused by some sort of annual cap on visits, since it occurred early in the calendar year. Thus, Moe's experience is not relevant to the instant grievance.

In summary, the Union's claim that insurance benefits have been unilaterally reduced by the County's insistence on determining medical necessity presents an issue that is, on its face, arbitrable. However, the right to require that treatments and procedures be medically necessary in order to be covered by insurance was an inherent feature of the Blue Cross insurance policy and has been carried over into the County's self-funded plan. Although it may have come as an unwelcome surprise to these employees, it is not a change or reduction in the level of benefits. The determination of medical necessity in individual cases may be challenged through the appeal procedures of the plan administrator, but is not a grievable issue under the labor contract. A fixed cap on chiropractic visits would be a violation of the labor agreement, but the single instance in which this is alleged to have been the basis for a denial of claims took place five years ago and was not grieved at the time. There is no evidence that any such cap exists today.

On the basis of the foregoing, and the record as a whole, I have made the following

AWARD

1. The grievance is substantively arbitrable;

2. The Employer did not violate Article 18, Section F, of the collective bargaining agreement when the Third Party Administrator denied certain chiropractic claims submitted by Diane Christenson;

3. The Grievance is denied.

Dated at Racine, Wisconsin, this 8th day of December, 2000.

Daniel Nielsen /s/
Daniel Nielsen, Arbitrator

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