

BEFORE THE ARBITRATOR

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In the Matter of the Arbitration of a Dispute Between

**CITY OF WAUWATOSA**

and

**WAUWATOSA PROFESSIONAL  
FIREFIGHTER'S ASSOCIATION, LOCAL 1923**

Case 135  
No. 68714  
MA-14323

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**Appearances at Hearing and on Brief:**

**Beth Aldana**, HR Director/Assistant City Attorney, City of Wauwatosa, 7725 West North Avenue, Wauwatosa, Wisconsin, 53213, appearing on behalf of the City.

**David Tippel**, Post Office Box 26214, Wauwatosa, Wisconsin, 53226, appearing on behalf of the Union.

**ARBITRATION AWARD**

The City of Wauwatosa (City) and the Wauwatosa Professional Firefighter's Association, Local 1923, (Union) are parties to a collective bargaining agreement that provides for final and binding arbitration of disputes arising there under. The Union, with the concurrence of the City, requested that the Wisconsin Employment Relations Commission designate a commissioner or staff member to serve as arbitrator of the instant dispute. The undersigned was so designated. A hearing, which was not transcribed, was held on June 17 and November 11, 2009 in Wauwatosa, Wisconsin. The record was closed on December 14, 2009; following receipt of the parties' post-hearing written argument. Having considered the record as a whole, the undersigned makes and issues the following Award.

**ISSUE**

At hearing, the parties stipulated to the following statement of the issue:

Was the contract violated when the City's health care administrator failed to pay inpatient diagnostic at 100%?

**RELEVANT CONTRACT LANGUAGE**

**Article VIII - Insurance**

Section 1: Health Insurance.

Effective January 1, 2005 and continuing for the term of this Agreement and its extensions, the health insurance coverage, at the City's expense, shall be identical to those provided to the employees on December 31, 2004 with the following modification:

A. Health Risk Assessment. The City will provide to full time members a Health Risk Assessment within 60 days of the plan year.

B. Routine and Preventive Care. Routine tests and procedures and preventive care shall be covered 100% in-network, 70% out-of-network.

C. Annual Deductibles With Health Risk Assessment. Effective January 1, 2005 employees who have had a current Health Risk Assessment shall pay the following annual deductible: In-Network \$100 for single, \$200 for family; Out-of-Network \$200 for single, \$400 for family. Effective January 1, 2007 employees who have had a current Health Risk Assessment shall pay the following annual deductible: In- Network \$200 for single, \$400 for family; Out-of-Network \$400 for single, \$800 for family.

D. Annual Deductibles Without Health Risk Assessment. Effective January 1, 2005 employees who have not had a current Health Risk Assessment shall pay the following annual deductible: In-Network \$200 for single, \$400 for family; Out-of- Network \$400 for single, \$800 for family. Effective January 1, 2007 employees who have not had a current Health Risk Assessment shall pay the following annual deductible: In-Network \$300 for single, \$600 for family; Out-of-Network \$500 for single, \$1,000 for family.

E. Out of Pocket Annual Maximum. Effective January 1, 2005, employees shall pay an \$800 individual out-of-pocket annual maximum or a \$1,600 family out-of-pocket annual maximum for in-network or out-of-network services. Effective January 1, 2006, employees shall pay a \$1,000 individual out-of-pocket annual maximum or an annual \$1,800 family out-of-pocket annual maximum for in-network or out-of-network services. The co-insurance for services provided by PPO members shall continue to be computed on the basis of 90% paid by the plan and, 10% paid by the employee, until the employee's out of pocket maximum is met. Effective January 1, 2004, the co-insurance for services provided by non-PPO members shall be computed on the basis of 70% paid by

the plan and 30% paid by the employee, until the employee's out of pocket maximum is met.

F. Lifetime Maximum. Effective January 1, 2006 the individual lifetime maximum shall be increased to \$2 million with no more than \$1 million per year.

G. Prescription Step Therapy. Effective January 1, 2005 prescriptions for the treatment of arthritis, GI/ulcer, and rheumatoid arthritis shall be managed by the concept of Step Therapy, which means that the physician shall present to the Pharmacy Benefits Manager medical information before beginning a new medication or changing to a higher cost medication. Treatment will begin with the lowest cost treatment protocol available to the plan beneficiary that does not cause or create concern to their health.

H. Retail Prescription. Effective January 1, 2005, employees shall pay \$12 for each generic prescription, \$20 for each formulary prescription, and \$31 or 20% (whichever is greater) not to exceed \$65 per prescription for each non-formulary prescription. Effective January 1, 2007, employees shall pay \$15 for generic prescriptions, \$24 for formulary prescriptions, and \$40 or 20% (whichever is greater) not to exceed \$80 per prescription for non-formulary prescriptions. Effective November 1, 1994, the quantity of prescribed drugs available each time a prescription is filled under the RESTAT drug card program shall be the greater of 100 units or a 34 day supply.

I. Mail Order Prescription. Effective January 1, 2005 for each maximum 90 day mail order prescription employees shall pay \$24 for each generic prescription, \$40 for each formulary prescription, and \$62 or 20% (whichever is greater) not to exceed \$130 for a non-formulary prescription. There shall be no reimbursement for employee prescription co-pays. Effective January 1, 2007 for each maximum 90 day mail order prescription employees shall pay \$30 for each generic prescription, \$48 for each formulary prescription, and \$80 or 20% (whichever is greater) not to exceed \$160 for each non-formulary prescription. There shall be no reimbursement for employee prescription co-pays.

J. Over-The-Counter Medications. Effective January 1, 2005 the plan will include coverage as a generic for the purchase of over-the-counter medications for which a prescription drug exists. This provision is limited to medications for acid reflux and allergy.

K. Effective January 1, 2005, there shall be a \$5,000 lifetime maximum on the diagnosis and correction of infertility but excluding in-vitro fertilization, infertility and artificial insemination services.

L. Chiropractic. Effective January 1, 2005, for chiropractic services the plan will pay 90% In-Network and 70% reasonable and customary Out-of-Network costs for a maximum of 36 visits per calendar year.

M. Optical Insurance. Effective January 1, 2005, the City shall provide VIPA 70 Gold or equivalent insurance with a \$10 deductible.

...

O. Effective November 1, 1994, the definition of "dependent" shall be the following: The employee's dependent shall be the employee's legal spouse. Eligible dependents shall also include the employee's unmarried children through the end of the month in which the child becomes 19 years old or through the end of the month in which the child becomes 25 years old if the child is a full time student at a recognized college, university, secondary or trade school and the employee provides at least 50% of his/her support. A dependent who is 19 years of age or older on January 1, 1995, shall be covered as provided by the previous definition of "dependent". A "child" includes a natural born child, legally adopted child, step-child or foster child. A dependent must not be either an employee of the City or in the armed forces of any country. To be eligible, a dependent must reside in the United States. (There is no change in the definition and coverage of a handicapped dependent.)

P. Effective December 31, 2001, the alcohol/drug and mental health coverage shall remain the same except for the following changes:

1. Inpatient Coverage: Effective January 1, 2002, the plan will cover 30 days of inpatient treatment per person per year at 100% and 40 days of inpatient treatment at the appropriate PPO or non PPO percentages, with an annual maximum of 70 days.

2. Effective on January 1, 2004, the outpatient nervous, mental, drug and alcohol benefit shall be changed to 10 office visits paid at 100% and 80 office visits at 90% for PPO providers and 70% for non PPO providers. The benefit is available annually to each eligible participant.

...

### **BACKGROUND**

The City of Wauwatosa Employee Benefit Plan document administered by Benefit Service Inc., hereafter BSI, states that it is effective June 1, 1997 and "Revised: September 01, 2002." Various letters from the City of Wauwatosa Personnel Department and "Plan Amendment" documents signed by the City's Personnel Director are attached to this BSI plan document.

One of these letters, dated October 7, 1998, is addressed to various individuals, including "Gary Vokovitch, Local 1923" and includes the following:

...

FROM: Carol Thomas

RE: Health and Dental Benefit Books

As previously stated, the purpose of creating updated health and dental benefit books is to set forth existing benefits and to comply with applicable law. Existing benefits are benefits written in the old booklet produced by The Traveler's company as modified by negotiated benefit changes since the time the booklet was in effect. The benefits are also modified to the extent that applicable law requires that they change.

...

Another of these letters, dated September 23, 2002, includes the following:

Dear Employee or Retiree

RE: Updated Health Plan Document

This letter is attached to two letters that should have been bound inside your health plan document. For some reason, when the books were assembled, the letters were omitted. Please keep them inside the book for future reference.

The changes in the book fall into three categories.

- Negotiated benefit changes: Prescription Drug benefits found on page 30 is an example.
- Corrections/clarifications: the second paragraph of Special Enrollment Rights is modified to make even clearer that a newborn baby must be enrolled within 30 days of his or her birth.
- Changes required by HIPAA (Health Insurance Portability Accountability Act.) The changes are scattered though out the document and bring the plan document into compliance with the law without changing your negotiated benefits.

Representatives of all the unions reviewed the book before it was printed.

...

The most recent “Plan Amendment” is dated “12/29/03.” The introductory paragraph to this “Plan Amendment” states as follows:

Effective January 1, 2004 the City of Wauwatosa Employee Benefits Plan has been amended to read as follows:

The Schedule of Benefits has been revised to read as follows:

...

The “Summary Plan Description Choice Plus Plan for City of Wauwatosa-Fire Union Employees” document identifies an “Effective Date” of “October 1, 2007.”

On or about January 9, 2009, Firefighter Bathke filed a grievance alleging that, on two separate occasions, members of his family had diagnostic testing; that United Health Care paid 90% of these charges; and that this 90% payment violated the parties’ labor contract because the covered rate for these charges, as bargained by the parties, was 100%. The City denied this grievance on the basis that the diagnostic testing involved inpatient services that are payable at 90%. Thereafter, the parties submitted the grievance to arbitration.

### **POSITIONS OF THE PARTIES**

#### **Union**

The City has a self-funded, self-insured insurance policy that is administered by a third party employed by the City. These third party administrators have included Travelers, WPS, Benefit Services Inc (BSI), and Auxiant. United Health Care (UHC) is the current third party administrator.

The Union agrees that the City has the right to change third party administrators. The Union argues that the City and the Union have negotiated insurance benefit levels and that the City may not unilaterally change these benefit levels. The Union asserts that Article VII, Section 1, of the parties 2005-2007 collective bargaining agreement supports this argument.

The UHC plan document (City Ex. #1), which was prepared by United Health Care and the City, is disputed by the Union on the basis that it is perceived to contain benefit changes that have not been negotiated with the Union. The BSI plan document (Jt. Ex. #3) is the most recent health insurance plan negotiated, agreed to and signed off by the Union.

The Union recognizes that, over time, the parties have negotiated some benefit changes not reflected in the BSI plan document. The benefit in question, *i.e.*, diagnostic coverage, has not been the subject of such negotiations.

When questioned by the Union, Michael Loy, the City's Health and Productivity Coordinator, acknowledged that the language on inpatient hospital services on pg. 15 of Jt. Ex. #3 and the language on pg. 16 of City Ex. #1 is not similar. This testimony supports the Union's position that there are differences between the BSI and the UHC plan documents and that the BSI SPD is controlling.

Individuals insured under Firefighter Bathke's City health insurance plan were admitted for inpatient care and received diagnostic procedures, *i.e.*, diagnostic x-ray and lab. The City argues that these diagnostic procedures are "miscellaneous inpatient" services and, thus, covered at 90%. The Union asserts that these diagnostic procedures, whether inpatient or outpatient, are covered at 100%.

Most of the descriptions of "Covered Services" in the BSI plan document do not reference percentage of coverage. The description of "Diagnostic Services" found on pg. 19 makes clear that laboratory and x-ray services are diagnostic procedures and that these diagnostic procedures may be provided inpatient or outpatient.

To determine the applicable payment percentage, one needs to reference pg. 2 of Jt. Ex. #3. Page Two lists a number of services that are differentiated based on inpatient and outpatient. The benefit in question does not have this differentiation.

City Witness Stephanie Steger stated that, during her years with Auxiant, claims coded as inpatient services were covered and paid at 90%. When questioned by the Union, Steger stated she could not recall how many claims were paid out as inpatient hospital services or how many claims involved inpatient diagnostic procedures. The Union maintains that Steger's testimony is too vague to substantiate the City's claim.

Steger states that the City tells the plan administrator how the benefits should be paid. The City may have told Auxiant to pay inpatient diagnostic at 90%, but that is not what was negotiated between the parties.

The EOBs offered by the Union, *i.e.*, Union Ex. 1-4, clearly show that inpatient diagnostic is covered at one hundred percent. It is self-explanatory that "IP" would stand for "Inpatient." If claims were paid out incorrectly in the past, the Union was not aware of such a fact.

The EOBs do not differentiate on the diagnostic code as to inpatient or outpatient. There is no need for a differentiation because each is paid at 100%.

The agreed upon benefit master plan (Benefit Services SPD) states that all diagnostic services, whether inpatient or outpatient, should be covered at 100%. The Union requests that the City follows this agreed upon plan.

City

The Union makes two arguments in support of its position: (1) the applicable plan document states that inpatient diagnostic claims are paid at 100% and (2) that similar claims from several years ago were paid at 100%. Each of these claims is erroneous. The Union admitted at hearing that its interpretation of the BSI document is based solely upon Firefighter Tippel's personal interpretation of the 2004 BSI plan document.

The City disputes the Union's assertion that the UHC plan document does not reflect the current benefit. However, for the purposes of this dispute, it does not matter because the UHC plan document, as well as the past plan documents, provide that inpatient diagnostic testing is paid at 90%.

In the BSI plan document, "Miscellaneous hospital expense" is defined at pg. 57 to include regular hospital charges, other than room and board. The definition describes that these expenses can apply to inpatient or outpatient services. Page 2 of the BSI plan document specifically delineates that "Inpatient Miscellaneous Charges" are paid at 90%.

The general rule in interpreting documents is that specific language controls over general language. Thus, the specific delineation of "inpatient miscellaneous charges" controls over any general language regarding diagnostic charges.

Auxiant administered the plan from 2004 to 2007. This administration was after BSI and prior to UHC. City Witness Steger, who was employed by Auxiant during that period, explained that inpatient diagnostic testing claims fell under inpatient miscellaneous charges and that such claims were paid at 90%. Steger testified that, during the time that Auxiant administered the plan, the charges in dispute would have been paid at 90%.

City Witness Beaudry has been a health insurance consultant for the City for over twelve years. She testified that, when the City changed third party health administrators, each new plan document paid inpatient diagnostic claims at 90%.

The provider codes the claims and bills the third party administrator. Notwithstanding any Union implication to the contrary, the City does not control how a provider codes a claim.

The claims report from UHC shows that outpatient charges for diagnostic procedures have been paid at 100% and that inpatient charges have been paid at 90%. Claims that the Union contended were inpatient diagnostic services paid at 100% were actually outpatient diagnostic services. There is no dispute that outpatient diagnostic services are paid at 100%.

The Union relies on BSI EOBs. There is no foundation laid through a witness with knowledge of whether these services were billed as inpatient or outpatient. These EOBs should not be given any weight.



This Union has been very involved in discussions of health insurance benefits. It is implausible that, if the Union had negotiated a benefit of inpatient diagnostic to be paid at 100%, that the Union would first raise this issue in 2009 when these claims have long been paid at 90%.

The City has not violated the collective bargaining agreement. The grievance should be denied.

## **DISCUSSION**

### **Issue**

The City argues that the Union's grievance is untimely because it was not filed within the time lines set forth in the contractual grievance procedure. At hearing, the parties stipulated to the following statement of the issue:

Was the contract violated when the City's health care administrator failed to pay inpatient diagnostic at 100%?

The undersigned has not addressed the City's timeliness argument because it is outside the scope of the parties' stipulated issue. Additionally, the Union has not been afforded a reasonable opportunity to litigate this issue.

### **Merits**

The parties agree that individuals insured under Firefighter Bathke's City provided health insurance plan received inpatient diagnostic x-ray and lab services in 2008. The parties further agree that the City's third party health insurance administrator paid 90% of the provider charges for this testing.

The Union relies upon Article VIII, Section 1, of the parties' 2005-2007 agreement to argue that the parties have negotiated the benefit levels of the master health insurance plan. The Union further argues that, with respect to the charges that are the subject of this dispute, the negotiated benefit levels are set forth in the City of Wauwatosa Employee Benefit Plan (hereafter BSI plan) and that, under this plan, the inpatient diagnostic testing received by individuals covered by Firefighter Bathke's insurance plan is required to be paid at 100%.

The City maintains that, under the mandated health insurance plan, diagnostic testing is paid at 100% if the place of service is outpatient and at 90% if the place of service is inpatient. The City asserts, therefore, that, in the instant case, the City satisfied its insurance obligation when it paid 90% of the charges for inpatient diagnostic testing.

Article VIII, Section 1, of the parties' 2005-2007 agreement includes the following language:

Section 1: Health Insurance.

Effective January 1, 2005 and continuing for the term of this Agreement and its extensions, the health insurance coverage, at the City's expense, shall be identical to those provided to the employees on December 31, 2004 with the following modification:

. . .

The 2005-2007 collective bargaining agreement is the only labor contract introduced into evidence and neither party argues that this agreement does not govern the grievance filed on January 9, 2009. The record reasonably indicates that the parties have extended the terms of the 2005-2007 agreement.

Documents accompanying the 2004 BSI plan document establish that the BSI plan is the health insurance plan document in effect on December 31, 2004. Accordingly, under the terms of Article VIII, Section 1, the City is obligated to provide the health insurance coverage provided under the 2004 BSI plan, as modified by the language of Article VIII, Section 1.

Neither party argues that the language of Article VIII, Section 1, includes any relevant modification to the 2004 BSI plan document. Nor does the language of Article VIII, Section 1, reflect any relevant modification.

The City argues that the "Summary Plan Description Choice Plus Plan for City of Wauwatosa-Fire Union Employees" (UHC plan document) provides the same benefit plan as the 2004 BSI plan document. The Union argues that its consultant has not finished its review of the UHC plan document and, thus, the Union does not concede that the two plans are the same.

The record is insufficient to conclude, as the City argues, that the UHC plan document provides the health insurance benefits mandated by Article VIII, Section 1. Accordingly, for the purposes of this dispute, the 2004 BSI plan document, rather than the UHC plan document, is the relevant plan document.

The BSI plan document includes a "Plan Amendment" that includes a list of "Covered Services" and assigns a "Percentage Payable" for Network and Non-Network charges. As the City argues, for most of the "Covered Services" this listing is the only place in the plan document that identifies how charges for "Covered Services" are to be paid.

The instant grievance involves two claims. One of these claims is for inpatient diagnostic x-ray and the other claim is for inpatient diagnostic lab.

The "Covered Services" listing identifies "Diagnostic X-ray and lab" as a service with a "Percentage Payable" of 100% Network and 100% R&C Non-Network. The City argues

that this listing refers only to Outpatient “Diagnostic X-ray and lab” and that Inpatient “Diagnostic X-ray and lab,” such as the claims in dispute, fall under the “Covered Services” listing of “Inpatient Miscellaneous Charges;” which has a Percentage Payable of 90%.

The Covered Services” listing includes an “Inpatient Surgical Expense Benefits” payable at 90% and an “Outpatient Surgical Expense Benefits” payable at 100%, as well as an “Inpatient Anesthesia” payable at 90% and an “Outpatient Anesthesia” payable at 100%. As the Union argues, this language suggests that, if “Percentage Payable” differs based upon place of service, then the “Covered Services” listing would express such a distinction.

In the present case, the “Covered Services” listing of “Diagnostic X-ray and lab” is more specific than “Inpatient Miscellaneous Charges.” As the Union argues, the plain language of the “Covered Services” listing suggests that diagnostic x-ray and lab services, whether Inpatient or Outpatient, are payable at 100%.

As the City argues, other provisions of the BSI plan document may provide assistance in determining the City’s insurance payment obligation with respect to the disputed claims. The BSI plan document includes the following language:

...

**DIAGNOSTIC SERVICES:** The following services (which are some examples) when performed for diagnosis of a condition, disease or injury and the Physician’s interpretation of these exams are covered under your Plan:

- X-ray examinations
- Laboratory and Pathology Services
- Diagnostic Medical Examinations such as EKG’s and EEG’s
- Cardiographic, encephalographic and radioisotope tests

Diagnostic services may be provided either in or out of a Hospital.

...

The above provision recognizes that “Diagnostic Services” encompass both Inpatient and Outpatient x-ray and lab services. This provision does not state that the “Percentage Payable” for “Diagnostic Services” differs based upon the place of service.

The BSI plan document defines “Miscellaneous Hospital Expenses” as:

-the regular hospital charges (but not room and board, nursing services and ambulance services) covered under the Plan for care of an illness or injury requiring either inpatient hospitalization or outpatient treatment of services at a hospital. For outpatient treatment or services, this includes charges for the hospital’s emergency room and emergency medical care at the hospital.

...

This definition recognizes that the term “Miscellaneous Hospital Expenses” encompasses both Inpatient and Outpatient services. Given the general nature of this definition, it is plausible that “Diagnostic Services,” such as “Diagnostic X-ray and Lab,” fall under the category of “Miscellaneous Hospital Expenses.”

The BSI plan document includes the following language:

...

## **HOSPITAL SERVICES**

Your protection against Hospital bills is provided through your Employee Benefit Plan. When you are admitted as a bed patient to any state approved Hospital, you will be entitled to all the following services of the Hospital as needed and to the extent available for:

### **Inpatient Hospital Services - Bed, board, and general nursing services**

- A room with two or more beds;
- A private room. The private room allowance is the Hospitals average semi-private room rate.
- A bed in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

### **Ancillary Services**

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services;
- Therapy services;

### **Outpatient Hospital Services**

- **Emergency Accident Care:** Services and supplies to treat injuries caused by an accident within 72 hours of the accident.
- **Emergency Illness Care:** Services and supplies (within 72 hours after the illness begins) to treat a sudden and acute medical condition *that is life threatening and requires prompt medical care. Examples of covered situations are heart attacks, kidney stones and strokes;*

- **Surgery:** Surgical services and supplies.
- **Preadmission Testing:** Outpatient tests and studies performed within 7 days prior to a scheduled Hospital admission. Benefits are payable at 100% of R&C.
- **Pre-Surgical Tests;** 100% of R&C for network and non-network Covered Expenses within 7 days of an outpatient elective surgery.

...

The above provision recognizes that “Diagnostic services” are “Ancillary Services.” One of the common definitions of the word “Ancillary” is “secondary” and, thus, it is plausible that “Ancillary Services” would be billed as “Miscellaneous Charges.”

In summary, there is language in the BSI plan document that supports the Union’s argument that all “Diagnostic X-ray and Lab” is payable at 100%. However, there is also language in the BSI plan document that supports the City’s argument that “Diagnostic services” are “Inpatient Miscellaneous Charges.” Inasmuch as there is language that supports each party’s position, the language of the BSI plan document is not clear and unambiguous.

Evidence of the plan’s administration may provide assistance in clarifying the ambiguous plan language. At hearing, the Union introduced an Explanation of Benefits” (EOB) from WPS for services provided under Firefighter Bathke’s City health insurance plan in 1995 (U. Ex. #1), as well as EOBs from BSI for services provided in 1997 (U. Ex. #2) and in 1999 (U. Ex. #3). These EOBs were introduced to show that, in the past, inpatient diagnostic testing was paid at 100%.

These EOBs predate January 1, 2005, the effective date of the relevant collective bargaining agreement. At hearing, the Union confirmed that, given the age of these EOBs, it was not able to obtain billing information on these EOBs.

At hearing, Firefighter Toppel stated his understanding that the benefits at issue had not changed since 1995. The City does not argue otherwise. According to the City, the Union has misinterpreted the information contained on these EOBs.

As the Union argues, the WPS EOB shows that WPS was billed for a hospital room with the dates of service “03-15-95 to 03-17-95” and that, during these same dates of service, “LAB” services were provided at this hospital that were paid at 100%. According to the Union, the concurrent dates of service establish that the referenced “LAB” charges were inpatient charges.

As City witnesses stated at hearing, an individual may receive outpatient services in conjunction with a hospital admission. Thus, while the evidence that the “LAB” services were provided within the same “dates of service” as the hospital room charge is consistent with the Union’s argument that these charges are inpatient “LAB” services, this evidence is insufficient to prove that the referenced “LAB” charges were billed and paid as inpatient charges.

In the WPS EOB, the “LAB” charge has a “Service Code” of 300. The EOB does not provide an explanation for “Service Code 300.”

Union Exhibit #2 includes an EOB for an “IP PHY VI” charge on “Service Dates” of “07-06-97;” “070797-070797;” and “070897-07897.” It also includes an EOB for an “IP HOSP MI” charge with “Service Dates of “070697-070897.”

Union Exhibit #2 includes an EOB for a “Diagnostic” charge with “Service Dates” of “070597-070597” and a “Diagnostic” charge with “Service Dates” of “070697-070697.” Each “Diagnostic” charge is from the same radiology group and paid at 100%.

Union Exhibit #3 includes EOBs for an “IP HOS” charge on “07/13/99-07/16/99” and “IP PHY” charges on “07/13/99” through “07/16/99.” Union Exhibit #3 includes a “Diagnostic” charge with “Service Dates” of “07/13/99-07/13/99” and a “Diagnostic” charge with “Service Dates” of “07/14/99-07/14/99.” Each “Diagnostic” charge is from the same radiology group and paid at 100%.

The Union assumes that “IP” means “Inpatient.” These EOBs, however, do not define “IP.” Nor do they identify “Diagnostic” as “IP.”

If “IP” refers to “Inpatient,” then the lack of an “IP” would support the City’s argument that, when Diagnostic testing is paid at 100%, then it is for outpatient service. However, the lack of an “IP” also would support the Union’s argument that no identifier is used because the plan does not distinguish such testing based on inpatient/outpatient place of service.

If “IP” does refer to “Inpatient, then the “Diagnostic” charge for “07-05-97” would not have occurred during the inpatient admission asserted by the Union. Unlike the WPS EOB, the BSI EOBs do not have a “Service Code” that may be compared to determine if the “Diagnostic” charge for “07-05-97” and the “Diagnostic” charges for July 13 and 14 were coded differently.

At hearing, the Union introduced EOBs for services provided under Firefighter Bathke’s City health insurance plan in 2006. (Union Ex. #4) These EOBs are from Auxiant. (U. Ex. #5 was withdrawn by the Union and, thus, is not a subject of this discussion.)

Union Exhibit #4 includes an EOB that shows charges for two “Diagnostic X-ray and Lab” services on August 4, 2006 paid at 100%. This same exhibit indicates “Hospital Miscellaneous” and “Hospital Room & Board” with dates of service “08/04-08/05/2006” paid at 90%. As with the BSI EOBs discussed above, the Union argues that these dates of service establish that the August 4, 2006 “Diagnostic X-ray and Lab” services were inpatient services.

City Exhibit #3 includes documentation from Auxiant that provides further explanation of the charges that are the subject of Union Ex. #4. This documentation establishes that the

August 4, 2006 “Diagnostic X-ray and Lab” charges were processed with an “Outpatient Hospital” “Point of Service.” In addition to refuting the Union’s claim that the August 4, 2006 “Diagnostic” testing was for inpatient services, the Auxiant documentation supports the conclusion that “Dates of Service” are not reliable indicators of the “Point of Service.”

As the Union argues and City witnesses acknowledge, it is possible for EOBs and billing information to have mistakes. The record, however, provides no reasonable basis to conclude that it was a mistake for Auxiant to process the August 4, 2006 “Diagnostic X-ray and Lab” charges with an “Outpatient Hospital” “Point of Service.”

Stephanie Steger, an employee of Auxiant, states that she managed the City’s account during the time that Auxiant managed the City’s health insurance plan. Steger recalls that Auxiant administered this plan from March 1, 2004 to September 2007.

As discussed above, the collective bargaining agreement requires the health insurance coverage to be identical to that provided on December 31, 2004. Thus, Auxiant was the plan administrator of the plan negotiated by the parties.

According to Steger, as plan administrator, Auxiant looked at the prior BSI plan to apply the correct benefits. Steger stated that she had reviewed the City’s plan and, based upon her review of this plan, inpatient diagnostic lab and x-ray charges fall under “Inpatient Miscellaneous Charges.” When asked how the City plan paid for inpatient diagnostic testing when Auxiant administered the health insurance plan, Steger responded that inpatient diagnostic was paid at 90% after deductible.

Rae Ann Beaudry has been a City health insurance consultant for at least twelve years. Beaudry states that, as the City’s health insurance consultant, she works with each plan administrator to have the new plan match the old plan. Beaudry further states that only outpatient diagnostic testing has been paid at 100%. Beaudry states that the City wants to encourage outpatient testing because it is the most cost effective.

Beaudry could not recall any specific discussion with any plan administrator regarding inpatient diagnostic services. Beaudry states that this grievance is the first dispute on how inpatient diagnostic lab and x-ray are paid.

The City asserts that the City requested United Health Care (UHC) to run a report on the same procedures that are the subject of this claim and, in response to this request, the City received City Ex. # 5. The earliest claim identified on this report is November 2007. The most recent claim identified on this report is May 2009. This report indicates that “Inpatient Hospital” is paid at 90% and “Outpatient Hospital” is paid at 100%.

This report does not contain any information that identifies UHC as the preparer of the report. The record does not include correspondence from the City identifying the requested information or from UHC identifying the information provided. No UHC representative

testified regarding the compilation of this report. The record does not include supporting documentation such as provider claims, UHC processing forms, or EOBs. In the view of the undersigned, there is insufficient foundation to consider City Ex. #5 as reliable evidence of the past administration of the City's health insurance plan.

### Conclusion

As discussed above, the language in the BSI plan document is not clear and unambiguous with respect to the issue in dispute. Rather, there is language in the BSI plan document that supports each party's position.

The Union introduced several EOBs that establish that Diagnostic lab and x-ray charges have been paid at 100%. However, the information on the EOBs is insufficient to establish that the Diagnostic lab and x-ray charges were for inpatient services. Additionally, documents from Auxiant establish that the "Place of Service" of one of these EOBs was "Outpatient."

City witness Steger, the Auxiant employee who managed the City's health insurance account, testified that, during Auxiant's administration of this plan, inpatient diagnostic testing was paid at 90%. The City's health insurance consultant, Beaudry, who testified that only outpatient diagnostic testing has been paid at 100%, supports this testimony.

In summary, the Union has the burden to establish that the City has violated the collective bargaining agreement as alleged in the grievance. In the present case, the record evidence is insufficient to establish that the contractually mandated health insurance plan requires the City to pay 100% of the charges for the inpatient diagnostic x-ray and lab claims at issue. Accordingly, the grievance is denied.

### AWARD

1. The Union has not established that the contract was violated when the City's health care administrator failed to pay inpatient diagnostic at 100%.
2. The grievance is denied and dismissed.

Dated at Madison, Wisconsin, this 12th day of February, 2010.

Coleen A. Burns /s/

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Coleen A. Burns, Arbitrator

CAB/gjc  
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