UFCW Local 1500 Welfare Fund

Associated Administrators, LLC Report

March 13, 2018

Bill Jensen
Jeff Ianniello
Kristen Barshinger

ASSOCIATED ADMINISTRATORS

Agenda

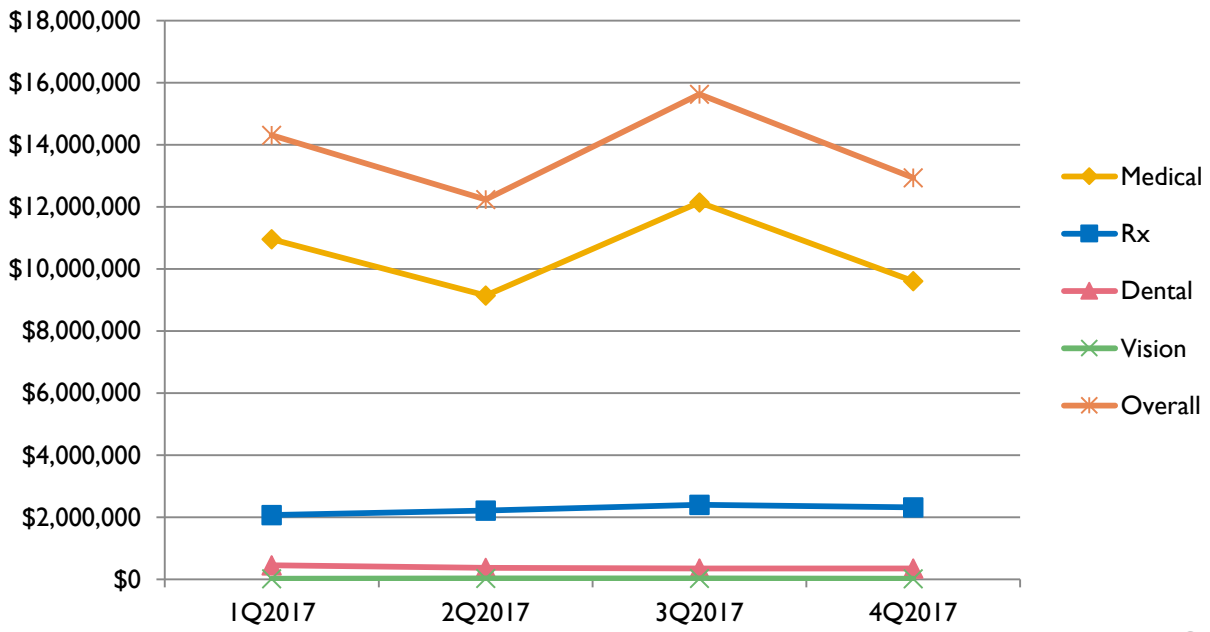
- AMR Summary and Claims Utilization Report 4Qtr 2017
  - Full Time
  - Special Part Time
  - Part Time ACA
  - Basic Part Time
  - Retiree
  - Summary and Reserve
- JAA Status Update
  - Snapshot
  - Top Five Health Conditions
  - Top Five Providers
- In-Network vs. Out-of-Network
- Out-Of-Network Discount Report
- Other Fund Business
- Tabled Appeals

AMR Summary : 4Q2017

Full Time Plan

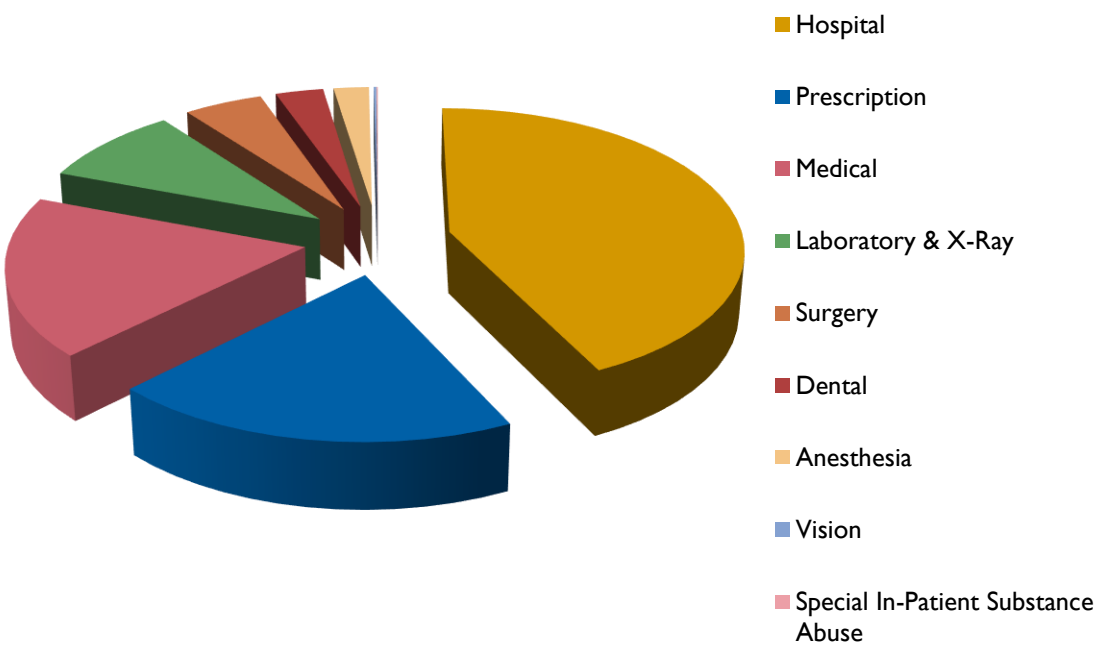
	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
Medical	$10,954,802	$9,146,723	$12,140,335	**$9,604,705**	$41,846,565
Rx	$2,069,933	$2,213,682	$2,403,177	**$2,317,559**	$9,004,351
Dental	$445,263	$367,927	$350,181	**$351,498**	$1,514,869
Vision	$18,195	$23,563	$22,974	**$18,450**	$83,182

- **4Q17 deficit of $143,161**
- **PPPM Cost 4Q17 - $1,264**



Claims – 4Q2017

FULL-TIME PLAN		
Hospital	$5,079,184.45	42.90%
Prescription	$2,317,559.00	19.57%
Medical	$2,161,974.26	18.26%
Laboratory & X-Ray	$1,064,176.61	8.99%
Surgery	$580,156.02	4.90%
Dental	$351,497.74	2.97%
Anesthesia	$259,281.52	2.19%
Vision	$18,450.00	0.16%
Special In-Patient Substance Abuse	$7,261.75	0.06%
		100%

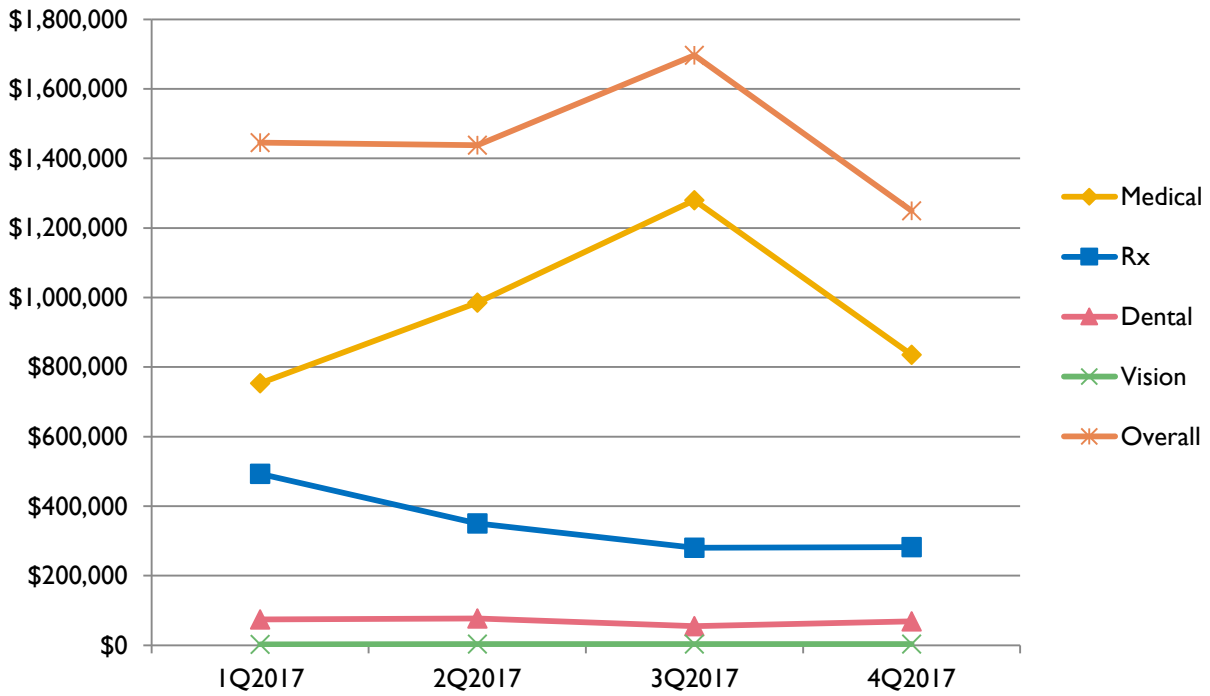


AMR Summary : 4Q2017

Special Part Time Plan

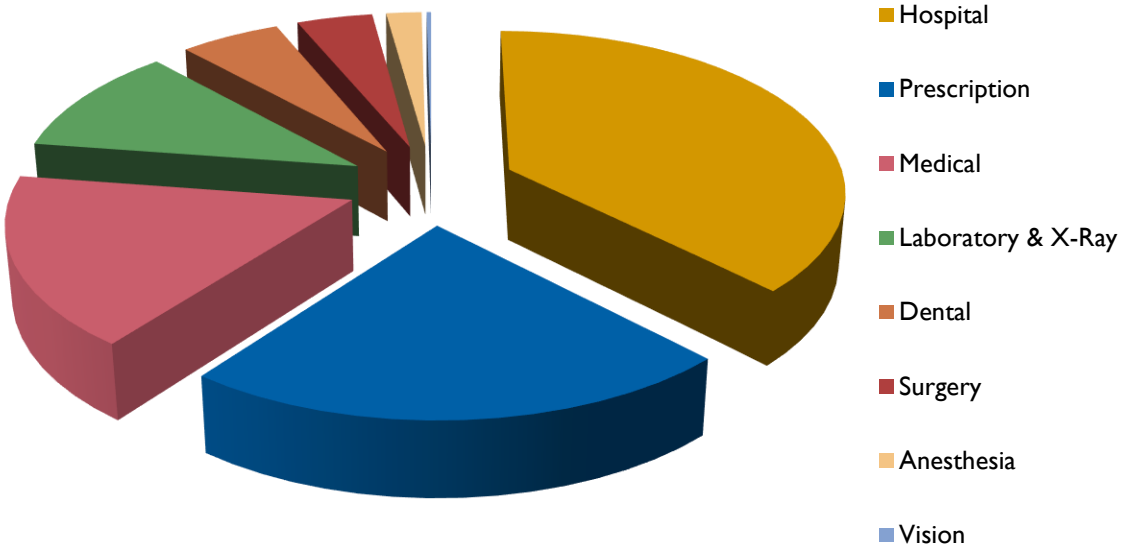
	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
Medical	$753,701	$984,847	$1,279,895	**$835,542**	$3,853,985
Rx	$492,816	$350,286	$279,925	**$282,319**	$1,405,346
Dental	$74,131	$77,110	$54,835	**$68,193**	$274,269
Vision	$2,283	$3,263	$3,438	**$2,992**	$11,976

- **4Q17 deficit of $44,658**
- **PPPM Cost 4Q17 - $474**



Claims cont'd – 4Q2017

SPECIAL PART-TIME PLAN		
Hospital	$466,927.86	37.62%
Prescription	$282,319.00	22.75%
Medical	$210,797.03	16.98%
Laboratory & X-Ray	$134,394.38	10.83%
Dental	$68,193.00	5.49%
Surgery	$51,491.43	4.15%
Anesthesia	$23,989.10	1.93%
Vision	$2,992.00	0.24%
		100%

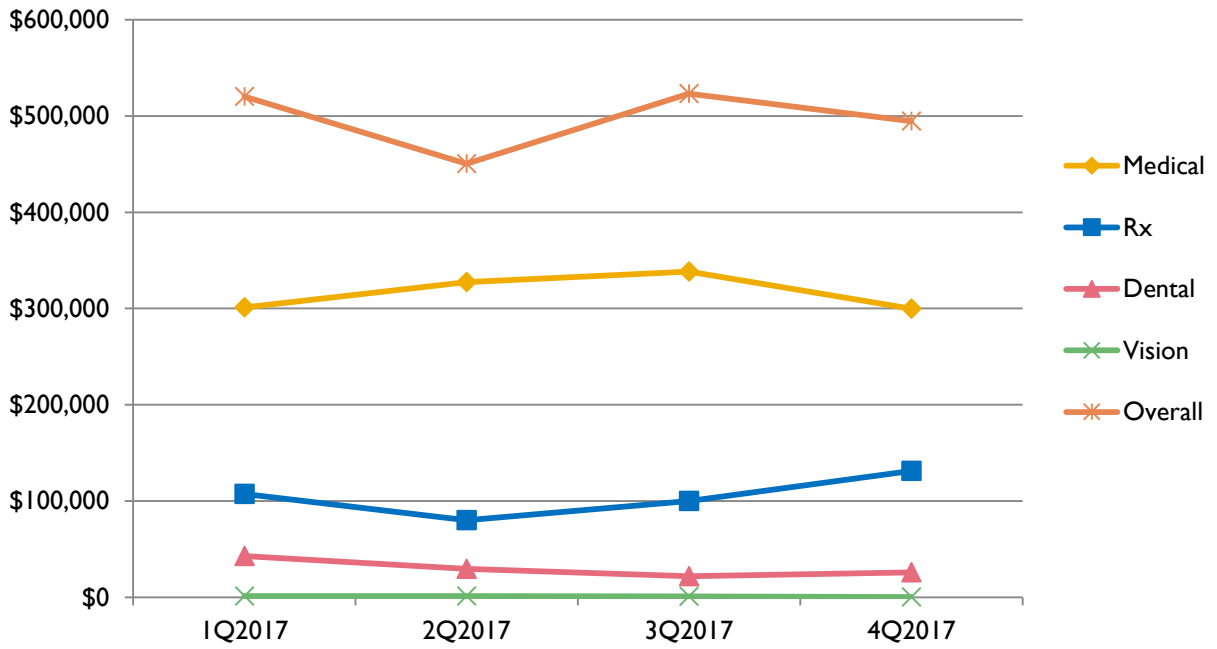


AMR Summary : 4Q2017

Part Time ACA Plan

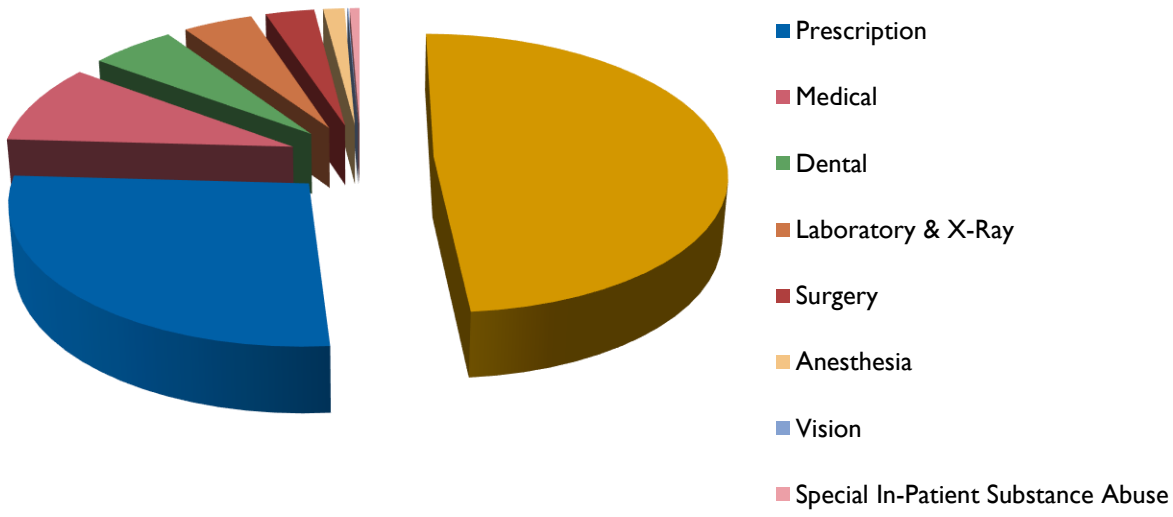
	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
Medical	$301,031	$327,393	$338,384	**$299,844**	$1,266,652
Rx	$107,235	$80,157	$100,091	**$131,308**	$418,791
Dental	$42,642	$29,379	$21,648	**$25,918**	$119,587
Vision	$1,112	$1,162	$900	**$295**	$3,469

- **4Q17 surplus of $242,910**
- **PPPM Cost 4Q17 - $285**



Claims cont'd - 4Q2017

PART-TIME ACA PLAN		
Hospital	$234,818.87	49.28%
Prescription	$131,308.00	27.56%
Medical	$44,401.03	9.32%
Dental	$25,917.95	5.44%
Laboratory & X-Ray	$21,324.36	4.47%
Surgery	$14,933.86	3.13%
Anesthesia	$6,521.23	1.37%
Vision	$295.00	0.06%
Special In-Patient Substance Abuse	($2,995.00)	-0.63%
		100%



JAA Claims – 4Q2017
Part-Time ACA Plan Deductible/Out-of-pocket maximum

- **31 members met their $5,600 deductible for the 2017 plan year by the end of the 4th quarter.**
- **Utilization below -- amounts shown include first $400 basic benefit.**

Member	AMOUNT PAID THROUGH 4Q2017
1*	$209,097.27
2	$173,629.21
3*	$173,219.36
4	$65,162.12
5*	$55,081.41
6*	$41,400.03
7*	$31,551.67
8	$30,912.48
9	$25,543.61
10	$17,100.18
11	$14,899.58
12*	$14,383.42
13*	$13,556.35
14*	$12,436.37
15	$12,243.28
16	$12,176.83

Member	AMOUNT PAID THROUGH 4Q2017
17	$10,298.95
18	$8,174.54
19	$5,736.64
20	$5,106.22
21	$4,888.50
22	$4,815.75
23*	$4,459.18
24	$3,578.28
25	$3,247.64
26*	$2,278.27
27*	$1,927.69
28	$990.01
29	$978.19
30	$499.13
31	$400.02

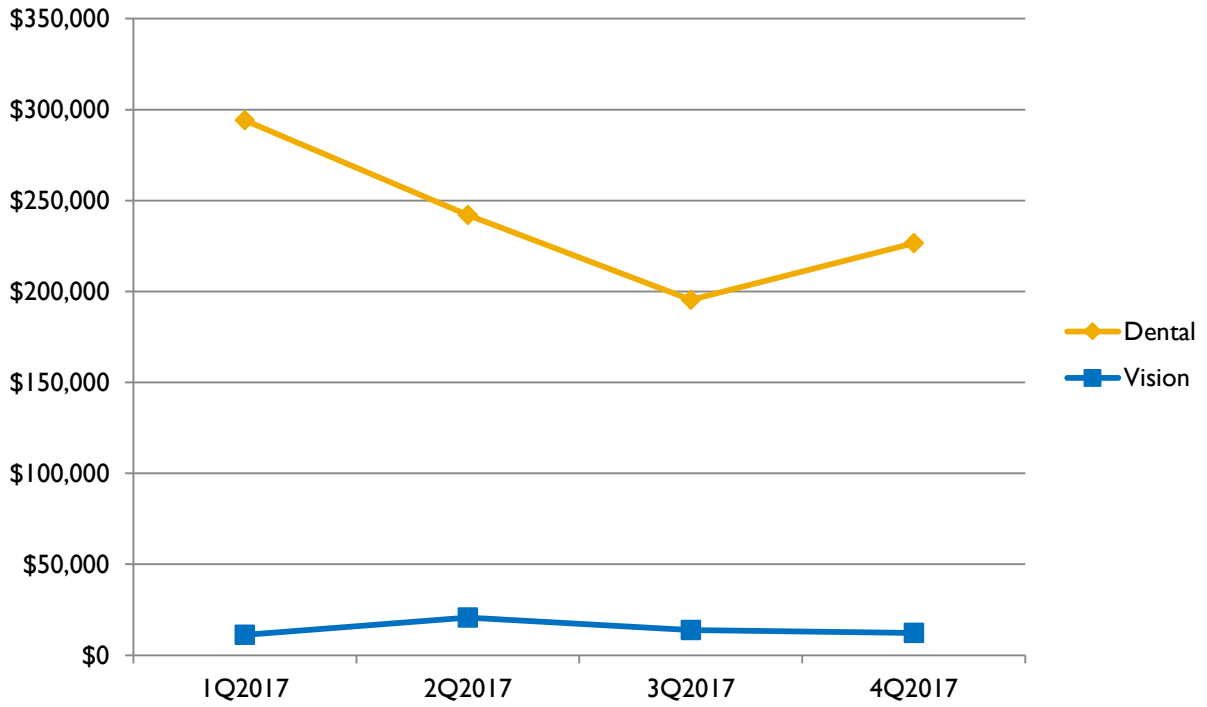
*Member's Part-Time ACA Benefits have terminated.

AMR Summary : 4Q2017

Part Time Plan

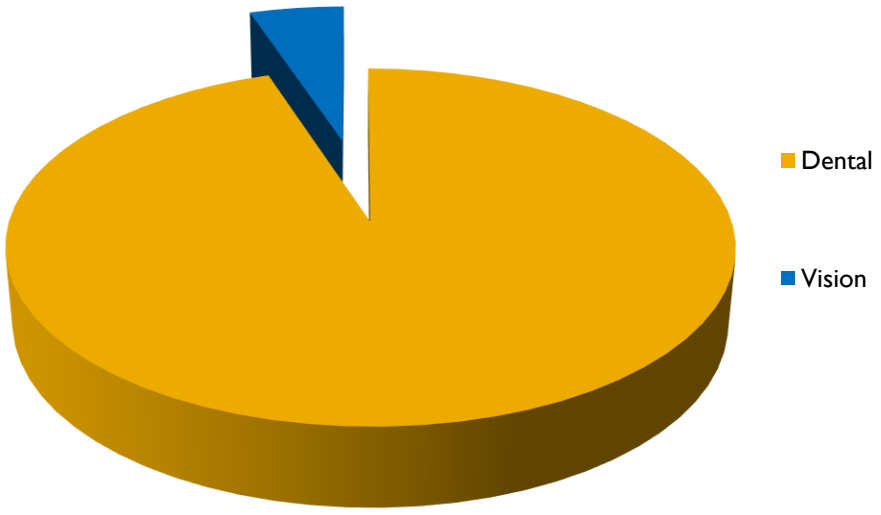
	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
Dental	$294,169	$242,046	$195,326	**$226,580**	$958,121
Vision	$11,191	$20,603	$13,870	**$12,185**	$57,849

- **4Q17 surplus of $2,659,772**
- **PPPM Cost 4Q17 - $20**



Claims cont'd – 4Q2017

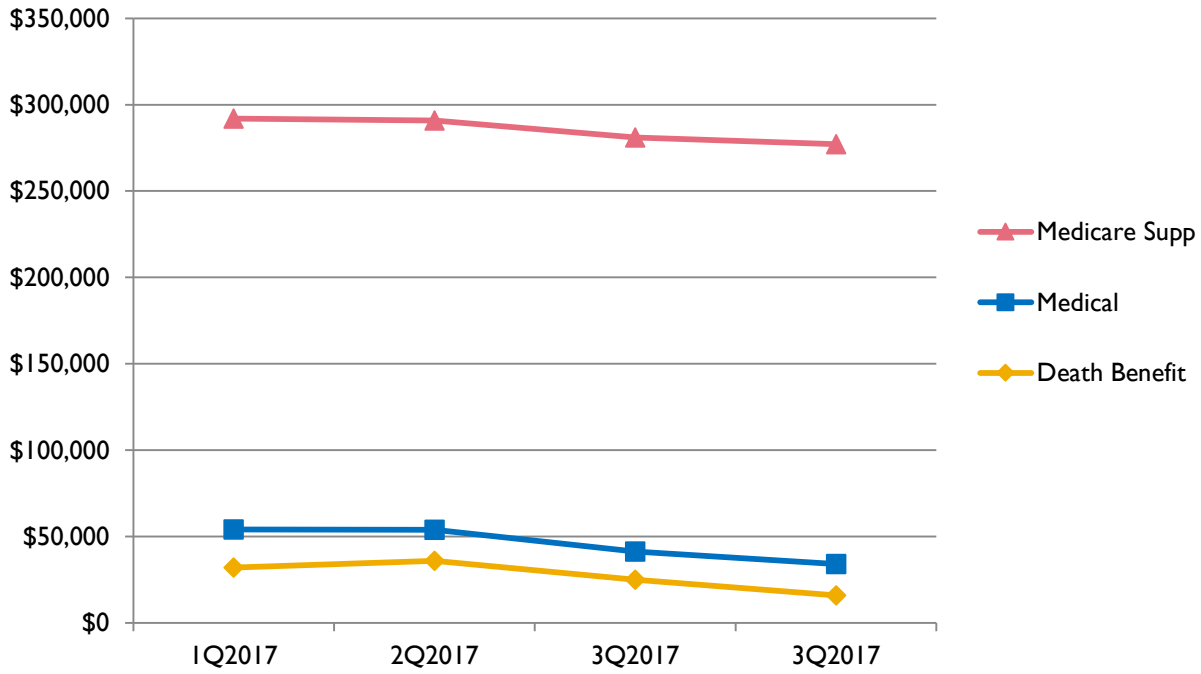
PART-TIME PLAN		
Dental	$226,579.85	94.90%
Vision	$12,185.00	5.10%
		100.00%



AMR Summary : 4Q2017

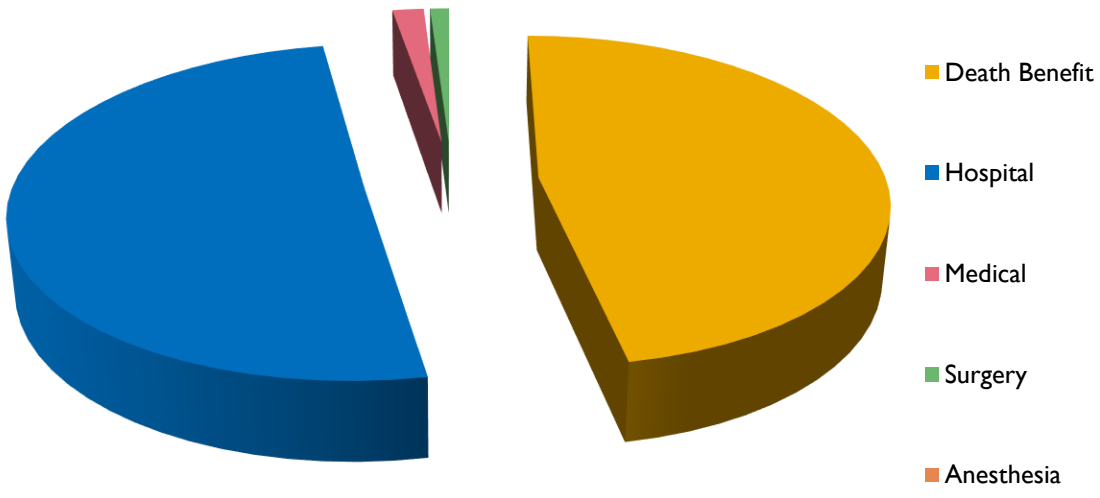
Retiree Plan

	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
Death Benefit	$32,000	$36,000	$25,000	**$16,000**	$109,000
Medical	$22,166	$17,940	$16,275	**$18,055**	$74,436
Medicare Supp Part B Reimbursement	$237,824	$236,886	$239,833	**$243,057**	$957,600



Claims cont'd - 4Q2017

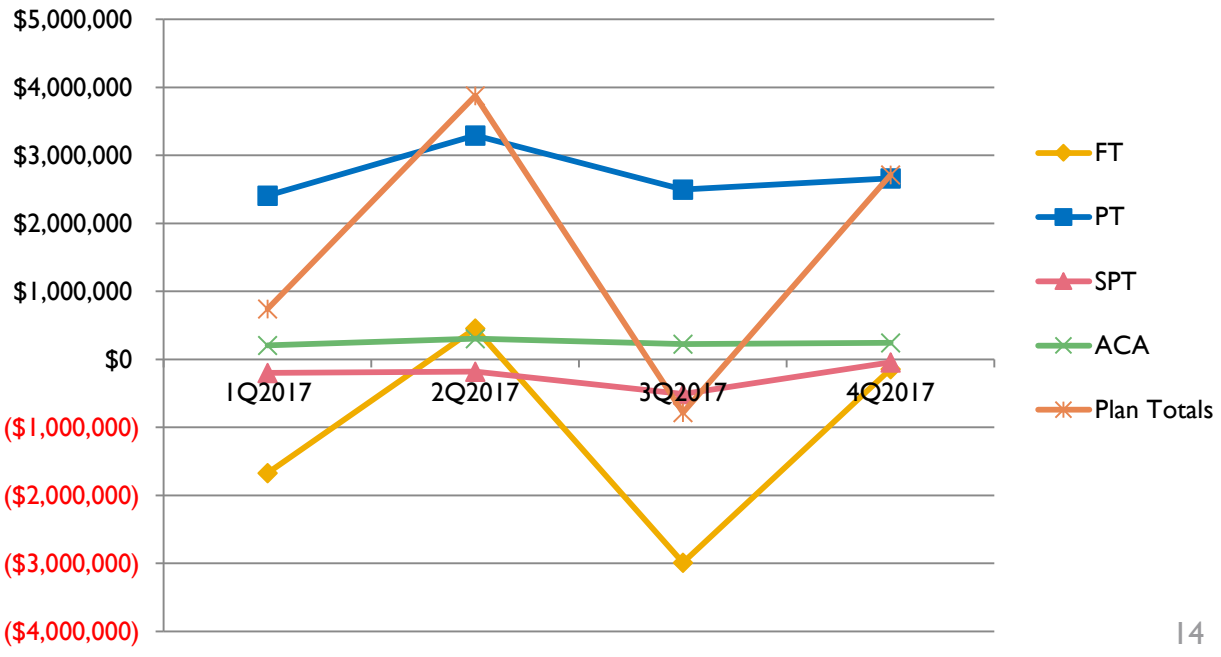
RETIREES		
Death Benefit	16,000.00	46.98%
Hospital	17,133.79	50.31%
Medical	574.20	1.69%
Surgery	346.72	1.02%
Anesthesia	-	0.00%
		100.00%



AMR Summary : 4Q2017

All Plans: Surplus/Deficit

	1Q2017	2Q2017	3Q2017	**4Q2017**	Previous 4 Quarters
FT	($1,669,922)	$456,000	($2,991,227)	**($143,161)**	($4,348,310)
PT	$2,407,933	$3,291,115	$2,495,908	**$2,659,772**	$10,854,728
SPT	($199,792)	($178,298)	($510,564)	**($44,658)**	($933,312)
ACA	$203,114	$306,572	$222,252	**$242,910**	$974,848
Plan Totals	$741,333	$3,875,389	($783,631)	**$2,714,863**	$6,547,954



AMR Summary : 4Q2017 Fund Reserve

- Average monthly expense July 2016 – December 2017 is **$5,623,444.07**

- Fund reserve amount is **$44,134,119**, as reported by Fund Auditor 12/31/17

12/31/17 – Fund reserve is 7.8 months

Monthly reserve at past quarterly meetings:

9/30/17	7.1 months
6/30/17	7.0 months
3/31/17	6.1 months
12/31/16	5.8 months
9/30/16	5.5 months

JAA Status Update

Snapshot

Month	Claims Processed	Billed Amount	Paid Amount	Difference
March '17	9,417	$11,745,209.64	$3,830,420.07	67.39%
April '17	7,629	$8,228,666.63	$2,730,832.01	66.81%
May '17	8,706	$10,407,457.51	$3,487,994.80	66.49%
June '17	9,272	$10,022,797.65	$3,095,844.26	69.11%
July '17	7,517	$11,719,690.72	$3,188,647.56	72.79%
August '17	8,841	$18,706,067.83	$5,883,489.39	68.55%
September ’17	7,424	$8,687,002.26	$2,897,887.00	66.64%
October ’17	8,301	$9,966,285.42	$2,983,095.78	70.07%
November ’17	7,741	$9,841,740.16	$3,505,757.13	64.38%
December '17	8,293	$10,575,799.91	$3,466,634.87	67.22%
January '18	7,660	$10,081,962.28	$3,002,485.97	70.22%
February '18	8,589	$12,954,318.89	$3,188,428.52	75.39%
Totals	**99,390**	**$132,936,998.90**	**$41,261,517.36**	**68.96%**

JAA Claims – 4Q2017

- Top 5 Diagnoses By Expense By Plan

FULL-TIME	
Amount Paid	**Diagnosis**
$227,528.17	Sepsis, unspecified organism
$181,681.73	Encounter for antineoplastic chemotherapy
$143,118.19	Gastric sleeve/gastric bypass (surgical procedure)
$156,579.26	Paroxysmal atrial fibrillation
$139,701.48	Opioid dependence treatment

PART-TIME ACA	
Amount Paid	**Diagnosis**
$66,433.95	Unspecified acute appendicitis
$50,597.26	Crohn's disease of large intestine with other complication
$44,553.00	Crohn's disease of both small and large intestine with intestinal obstruction
$40,600.00	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
$11,409.58	Acute appendicitis with localized peritonitis

JAA Claims – 4Q2017

- Top 5 Diagnoses By Expense By Plan

SPECIAL PART-TIME	
Amount Paid	**Diagnosis**
$86,954.18	Type 2 diabetes mellitus with foot ulcer
$77,742.47	Gastrostomy infection
$57,650.42	Atherosclerosis of coronary artery bypass graft(s) without angina pectoris
$42,009.11	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
$33,977.17	Incisional hernia without obstruction or gangrene

JAA Claims – 4Q2017

- Top 5 Providers By Expense By Plan

FULL-TIME	
Provider	**Amount Paid**
STONY BROOK UNIVERSITY HOSPITAL	$655,537.06
MONTEFIORE MEDICAL CENTER	$447,760.70
WESTCHESTER COUNTY HEALTH CARE	$297,333.90
GOOD SAMARITAN HOSP MED CTR	$253,384.15
HUDSON VALLEY HOSPITAL CENTER	$248,376.00

PART-TIME ACA	
Provider	**Amount Paid**
HACKENSACK MEDICAL CENTER	$110,883.82
NY PRESBYTERIAN HOSPITAL	$61,273.38
THE VALLEY HOSPITAL	$40,600.00
MONTEFIORE MEDICAL CENTER	$13,444.43
NASSAU HEALTH CARE CORP	$11,586.22

JAA Claims – 4Q2017

- Top 5 Providers By Expense By Plan

SPECIAL PART-TIME	
Provider	**Amount Paid**
PLAINVIEW HOSPITAL	$91,064.99
NYU HOSPITALS CENTER	$67,821.37
MERCY MEDICAL CENTER	$52,237.08
HUDSON VALLEY HEMATOLOGY-ONCOLOGY	$44,173.70
NEW YORK METHODIST HOSPITAL	$42,009.11

In-Network vs. Out-of-Network : 4Q2017

- **Inpatient Facility Utilization**
  - **In-Network Total: $3,618,043.19**
    - Full-Time: $3,201,825.54
    - Part-Time ACA: $158,398.73
    - Special Part-Time: $257,818.92
  - **Out-of-Network Total: $0.00**

- **Outpatient Facility Utilization**
  - **In-Network Total: $2,141,560.52**
    - Full-Time: $1,869,720.69
    - Part-Time ACA: $70,846.24
    - Special Part-Time: $200,993.59
  - **Out-of-Network Total: $22,441.50**
    - Full-Time: $22,441.50
    - Part-Time ACA: $0.00
    - Special Part-Time: $0.00

- **Inpatient & Outpatient Professional Fees**
  - **In-Network Total: $4,323,706.39**
    - Full-Time: $3,830,162.64
    - Part-Time ACA: $89,759.38
    - Special Part-Time: $403,784.37
  - **Out-of-Network Total: $252,887.16**
    - Full-Time: $227,884.24
    - Part-Time ACA: $0.00
    - Special Part-Time: $25,002.92

HRGi
Out-Of-Network Discounts

- October 2017 Invoice – Total billed $99,564.26
  - Discount: $44,437.52 – net of fees
  - Average: 45% per claim
- November 2017 Invoice – Total billed $113,722.09
  - Discount: $67,418.11 – net of fees
  - Average: 59% per claim
- December 2017 Invoice – Total billed $108,201.43
  - Discount: $54,357.33 – net of fees
  - Average: 50% per claim
- January 2018 Invoice – Total billed $79,673.45
  - Discount: $39,559.85 – net of fees
  - Average: 50% per claim

October 2017 through January 2018

Total billed: $401,161.23

Total discount: $205,772.81 – net of fees

Average: 51.29%

Other Fund Business

- Plan Reporting – ACA sections 6055 and 6056
  - Form 1095-B was mailed to all applicable participants in January 2018
- Disclosure of Creditable Coverage – CMS filing 2/21/18
  - Rx coverage – Medicare-eligible participants

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Hospital/Medical – Request for Lien Reduction #M18/117-5363

FUND RULE:
"**Subrogation**

Rights of Subrogation and Reimbursement
If you incur covered expenses for which a third party may be liable, or if you become entitled to other benefits as a result of the same events which caused you to incur the medical expenses, you are required to advise the Plan of that fact.

The Plan may pay such expenses provided that you agree, in writing, to reimburse the Plan, in full, from any settlement, judgment, or other payment that you obtain from the liable third party. Other expenses, including attorneys' fees, cannot be taken out of the payment. The Plan is entitled to such reimbursement from the proceeds of a judgment or settlement even if nothing in the judgment or settlement allocates any portion of the proceeds to medical expenses. Moreover, the Plan is entitled to reimbursement from any trust or fund set up for your benefit under a trust.

The Trustees will require you (or your authorized representative if you are a minor or incapacitated) and your attorney to execute this Plan's lien forms before this Plan pays you any benefits related to such expenses.

No benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan if you retain another attorney or an additional attorney since that attorney will be required to execute the form and acknowledge the Fund's lien."
(UFCW Local 1500 Full Time Employees Group Benefit Plan SPD, Pages 84-85)

SUMMARY: Appeal Received: March 8, 2018

The **participant's attorney** is appealing to be allowed a reduction in the Fund's lien related to a third party accident of November 2, 2016. The participant's attorney states, "Our office represents [the participant] for injuries and damages that she sustained as a result of a motor vehicle accident that occurred on November 2, 2016. This damage includes the loss of [her] unborn child. [The participant] has been made an offer to settle her case in the amount of $100,000.00 which is the insurance policy limit. Although this is the maximum amount that we can collect for her, this amount cannot make [her] whole when considering that she lost her child. We are in receipt of your current lien in the amount of [$21,731.72] and respectfully request that the lien be reduced to $5,000.00. While we understand that Local 1500 has asserted a valid lien for the above amount, we are respectfully requesting that the reviewing Board please consider [the participant's] excruciating circumstances and grant our request for a reduction."

A Subrogation Agreement (without the attorney's signature) was received on February 15, 2018. The participant's lien with the Fund is $21,731.72.

Note: The participant's third party claim has settled.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time
Deceased, December 16, 2016

ISSUE: Hospital/Medical – Medical Necessity #M17/184-6201

FUND RULE:
"Medical Limitations and Exclusions
- Treatment, services, prosthetics, or orthotic appliances which, in [the Fund's] judgment, are not medically necessary or appropriate."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Page 47)

SUMMARY:

Date(s) of Service:	December 5, 2016 through December 7, 2016
Claim Received:	January 31, 2017
Claim Denied:	February 15, 2017
Appeal Received:	July 21, 2017

The **provider,** Visiting Nurse Service of New York, is appealing for payment of a claim that was denied. The provider states that they rendered services in good faith.

Visiting Nurse Service of New York submitted claims for inpatient hospice services rendered from November 25, 2016 through December 7, 2016 with the diagnosis "Malignant neoplasm of bronchus or lung." HealthLink certified the services rendered from November 25, 2016 through December 4, 2016 only and the charges for services rendered from November 25, 2016 through December 4, 2016 were paid, up to the limits of the Plan. HealthLink advised the participant and the provider on December 5, 2016 that inpatient services rendered after December 4, 2016 were **not medically necessary.** HealthLink stated, **"We cannot approve coverage for comfort care in a hospice. Your request tells us you have lung cancer that has spread. We see that you need oxygen and pain medications. We have not been told of a medical reason why you cannot have this care at home. For this reason, we cannot say that this [inpatient] care is medically necessary for you."** The charges for services rendered from December 5, 2016 through December 7, 2016 were denied because they were not certified by HealthLink.

After the appeal was received, Associated Administrators contacted HealthLink on July 24, 2017. HealthLink advised on October 13, 2017, **"[The participant's] request for inpatient hospice is not approved. It is considered not medically necessary for the treatment of lung cancer. [The participant] did not have symptoms like severe uncontrolled pain, shortness of breath, or vomiting which could not have been managed with hospice support at home."** After the record was confirmed, the claim for inpatient services rendered from December 5, 2016 through December 7, 2016 remained denied because they were deemed **not medically necessary.**

Note: Visiting Nurse Service of New York also submitted a claim for home hospice services rendered from December 8, 2016 through December 16, 2016. That claim was paid, up to the limits of the Plan. The participant passed away on December 16, 2016.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**
REGARDING:

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Hospital/Medical– Experimental/Investigational #M17/163-6875

FUND RULE:
"Medical Limitations and Exclusions
Technology including treatments, procedures, drugs, biological, and medical devices that, in [the Fund's] sole discretion, are not medically necessary in that they are one of the following:
- Experimental
- Investigational

Experimental or investigational means either of the following definitions:
- The technology is not of proven benefit for either the particular diagnosis or the treatment of your condition.
- The technology is not generally recognized by the medical community (as reflected in the published peer-review medical literature) as either effective or appropriate for the particular diagnosis or treatment of your particular condition.

[The Fund] may apply any or all of the following… criteria when determining whether a technology is experimental, investigational, obsolete, or ineffective:
- Any medical device, drug, or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Pages 47-48)

SUMMARY:

Date(s) of Service:	February 13, 2017
Claim Received:	February 16, 2017
Claim Denied:	February 21, 2017
Appeal Received	May 11, 2017 (closed) - October 24, 2017 (reopened)

The **participant's spouse** is appealing for payment of a claim that was denied. The participant's spouse states, "I am a Type 1 diabetic. I have had diabetes since age seven and have been dealing with diabetic retinopathy since November 2010. My eyes have been depending on laser treatments and Avastin injections numerous times to help stop the leaking blood vessels in my eyes for nearly seven years. My eyes depend on these treatments and will continue to depend on these treatments for the rest of my life. On February 13, 2017, I went to see Dr. Sherry Solomon because my right eye had a rather large bleed. Dr. Solomon treated me with an Avastin injection... This injection was not experimental or investigational. It was medically necessary. It sealed the leaking blood vessels and helped clear out the remaining blood… Since I received the injection in February, my right eye is doing much better." The **provider**, Dr. Sherry Solomon, is also appealing for payment of this same claim.

Dr. Sherry Solomon submitted a claim for an intravitreal Avastin (generic bevacizumab) injection with the diagnosis "Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema." The claim was denied because Avastin has not been FDA-approved for the treatment of this diagnosis.

After the appeal was received, the record was reviewed with HealthLink. Medical records received from the provider on October 24, 2017 were forwarded to HealthLink for review on November 7, 2017. HealthLink advised Associated Administrators, LLC on February 1, 2018 that the treatment **is medically necessary.**

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**
REGARDING:

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Hospital/Medical – Preauthorization, Benefit Maximum #M18/116-4377

FUND RULE:
"Physical Therapy, Physical Medicine, and Rehabilitation
Room and board are covered in participating hospitals, for up to 30 days each calendar year, for stays or portions of stays primarily for physical therapy, physical medicine, and rehabilitation. These services must be performed under programs approved by the New York State Department of Health."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Page 37)

SUMMARY: Appeal Received: March 6, 2018

The **provider** is appealing on behalf of the participant's spouse for an addition to the benefit maximum for acute inpatient rehabilitation services.

Dr. Thomas N. Bryce, Dr. Avniel Shetreat-Klein, and Dr. Jing Wang submitted claims for daily acute inpatient rehabilitation services from February 16, 2018 through March 1, 2018 with the diagnoses "Quadriplegia - C5-C7 incomplete, neurogenic bowel, acute embolism and thrombosis of left femoral vein, and neuromuscular dysfunction of bladder." The claims were paid up to the limits of the Plan. The participant's spouse will exhaust the 30-day inpatient rehabilitation benefit for calendar year 2018 on March 17, 2018 if services continue without interruption.

Associated Administrators, LLC's records indicate the participant's spouse sustained a spinal cord injury resulting from a fall at home on January 15, 2018. The participant's spouse underwent a spinal fusion on January 16, 2018 and received acute hospital care from January 16, 2018 through February 15, 2018. At that time, she was transferred to inpatient acute rehabilitation with a goal discharge date of March 20, 2018.

Per plan rules, inpatient rehabilitation is limited to 30 days per calendar year which would allow payment from February 15, 2018 through March 17, 2018. The provider is appealing for continued care through the date of discharge. If the goal discharge date of March 20, 2018 is met, an additional 3 days of inpatient acute rehabilitation would need to be approved.

HealthLink states additional inpatient rehabilitation beyond the 30 day maximum allowed by the plan is medically necessary for the patient.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Prescription Benefit – Coverage of Brand Name Drug #Rx18/106-1934

FUND RULE:
"**Prescription Drug Benefit**
When a brand name drug has a generic equivalent, you may get the brand name, but you will be responsible for the difference between the cost of the brand name drug versus the cost of its generic equivalent, plus the co-payment."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Page 69)

SUMMARY: Appeal Received: January 26, 2018

The **provider,** Dr. Laura G. Schoenberg, is appealing on behalf of the participant for coverage of Keppra and Lamictal, which are brand name drugs. Dr. Schoenberg states, "The patient has tried the medications Dilantin, Tegretal, Phenobarbital and Depakote in the past. She had brain surgery for seizures. She had nausea and break through seizures with generic Lamictal and Keppra. It is medically necessary for the patient to have the brand [name] of these medications."

After the appeal was received, letters were mailed to the participant and Dr. Schoenberg on February 1, 2018 and February 16, 2018 requesting complete medical records related to her trial and failure with the generic forms of Keppra and Lamictal. On February 26, 2018, Associated Administrators, LLC received medical records from Dr. Schoenberg which were dated November 28, 2016 and May 15, 2017. The records were forwarded to NYCHSRO/MedReview at that time. NYCHSRO/MedReview advised Associated Administrators, LLC on March 5, 2018 that brand name Keppra and Lamictal **are medically necessary.**

Note: The Fund's medical consultant determined in 2013 and 2014 that brand name Keppra and Lamictal were medically necessary and the participant was granted coverage upon appeal in 2014, 2015, and 2016 at the co-payment level (without responsibility for the difference between the cost of the brand name drugs versus the cost of their generic equivalents).

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Special Part Time

ISSUE: Prescription Benefit – Coverage of Brand Name Drug #Rx17/230-8851

FUND RULE:
"**Prescription Drug Benefit**
The Local 1500 Welfare Fund is a Mandatory Generic Reimbursement Plan. You may continue to obtain a prescription drug written for a brand name, when there is NO generic equivalent available, and pay the applicable co-payment. You may choose a generic equivalent drug product when there is one available and ONLY pay the applicable co-payment. However, when a brand name drug has a generic equivalent, you may get the brand name, but you will be responsible for the difference between the cost of the brand name drug versus the cost of its generic equivalent, plus the co-payment."
(UFCW Local 1500 Part Time Employees Benefit Plan SPD, Page 28)

SUMMARY: Appeal Received: December 20, 2017

The **provider,** Dr. Jeffrey N. Elfenbein, is appealing on behalf of the participant for coverage of Tegretol, which is a brand name drug. Dr. Elfenbein states that the participant has been prescribed Tegretol for a seizure disorder. "It is medically necessary for her to take the brand [name] form of Tegretol 200mg because the generic form of Tegretol gives her seizures."

The Fund's medical consultant determined in 2013 and 2015 that brand name Tegretol was medically necessary and the participant was granted coverage for one year at the co-payment level (without responsibility for the difference between the cost of the brand name drug versus the cost of its generic equivalent). The Board of Trustees approved coverage of brand name Tegretol upon appeal in 2013, 2014, 2015, and 2016.

Medical records, received with this appeal, were sent to MRIoA for an updated review. MRIoA advised Associated Administrators on December 29, 2017 that brand name Tegretol **is not medically necessary**. MRIoA stated, "There is no specific medical necessity for brand name medication (Tegretol) either in the immediate or extended-release form. Both Tegretol and generic carbamazepine have the same active ingredient, carbamazepine. While there are often differences in bioavailability between different preparations, there is no evidence that the same level of medication in a patient on a generic formulation [will] have different efficacy than that derived from a brand name preparation. If serum levels of carbamazepine are measured, and levels are kept [in] the therapeutic range for the patient, there will be no difference in efficacy on generic carbamazepine compared with brand name carbamazepine. Therefore, as there is no difference in efficacy between brand name and generic carbamazepine given consistent serum levels, there is no specific medical necessity for brand name Tegretol."

This appeal was presented to the Board of Trustees in the January 2018 Appeals Book and denied.

After the appeal was denied, additional clinical information was received from the participant which was forwarded to NYCHSRO/MedReview on February 27, 2018. NYCHSRO/MedReview advised Associated Administrators on March 5, 2018 that brand name Tegretol **is medically necessary.** NYCHSRO/MedReview stated, "This patient developed seizures at 15 years of age which are described as generalized tonic-clonic seizures, with tongue-biting and post-ictal confusion. It appears from the notes that this patient was in good seizure control since 2012 or 2013. At some point it appears that she was switched from the brand name Tegretol to generic carbamazepine. On December 4, 2017, she apparently had a generalized seizure, while at work. She was taken to St. Joseph's Hospital, where she had a second seizure in the ER."

NYCHSRO/MedReview further stated, "On December 13, 2017 she was seen in her physician's office, and under the list of medications she was taking was carbamazepine, 200 mg. tablets, taking 2 tablets (400 mg) twice daily. At that visit, her physician switched her to Tegretol XR 400 mg, 1 tablet twice daily. If indeed she was switched to the generic form of the medication, and patient had 2 break-through seizures as a result, then she must be back on the brand name medication as prescribed by her Physician. This is even more crucial as it appears that patient has two jobs, and is driving, so complete seizure control is essential. In New York State, the patient should not be driving for at least 1 year after a seizure, in order to insure seizure control before she resumes driving."

On March 8, 2018 Associated Administrators advised NYCHSRO/MedReview that the patient was taking the brand name medication when she had seizures in December 2017. Associated Administrators asked if this information would change NYCHSRO/MedReview's opinion regarding the medical necessity of the brand name medication. NYCHSRO/MedReview will respond shortly.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

Conclusion

- Thank You
- Questions?