ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

HEALTH AFFAIRS

14 APR 1980

FINAL DECISION: [redacted] (Deceased) Appeal
Appealing Party)
(Staff Builders Medical Services,
Appealing Party)
OASD(HA) Case File 15-79

The Hearing File of Record and the Hearing Officer's RECOMMENDED DECISION (along with the Memorandum of Concurrence from the Director, OCHAMPUS) on OASD(HA) Appeal Case No. 15-79 have been reviewed. The amount in dispute in this case is $7,052.42. It was the Hearing Officer's recommendation that the Contractor's initial determination to deny benefits for the private duty nursing services rendered in the home from 21 July 1977 through 1 December 1977, and in the hospital from 2 December 1977 through 9 December 1977, be upheld. It was his finding that the disputed private duty nursing services were primarily custodial in nature, essentially designed to assist the beneficiary/patient (now deceased) in meeting the needs of daily living and to provide supportive care during the terminal phase of her illness. The Hearing Officer noted that the Program had approved the payment of benefits for one (1) hour per day of the private duty nursing services and for the cost of the prescription drugs and medicines utilized by the patient and supported this position. The Principal Deputy Assistant Secretary of Defense (Health Affairs), acting as the authorized designee for the Assistant Secretary, generally concurs with this recommendation and accepts it as the FINAL DECISION, except that it is revised to the extent that it has been determined that CHAMPVA benefits for the one (1) hour of skilled nursing care may only be provided for the home nursing care. No benefits may be extended for the inpatient nursing services rendered from 2 December through 9 December 1977.

PRIMARY ISSUE

The primary issue in dispute in this case is whether the services rendered by the private duty nurses (RNs/LPNs) constituted skilled nursing care or whether the services were primarily custodial in nature.

By law, CHAMPUS is precluded from paying its benefits for custodial care. Chapter 55, Title 10, United States Code, Section 1077(b)(1) specifically excludes custodial care. Further, the applicable CHAMPUS Regulation defines skilled nursing services as those services, "... which can only be furnished by RN (or LPN or LVN), and required to be performed under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result." It excludes from skilled nursing services "... those services which primarily provide support for the essentials of daily living or which could be performed by an untrained adult with minimum instruction and/or supervision." [emphasis added] (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter II, Subsection B. 161.)

Custodial care is defined as, "... that care rendered to a patient (1) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored and/or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical and/or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored and/or controlled environment." The regulation also states, "... a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a R.N. or L.P.N.." [emphasis added] (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter II, Subsection B.46.)

The applicable regulation, in that portion speaking to benefits and limitations, further outlines the scope of the private duty nursing benefit, and admonishes, "In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available for only a portion of the care..."; it also provides that inpatient private duty nursing may only be considered for benefits if the hospital does not have an Intensive Care Unit. [emphasis added] (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Section C, Paragraph n.(1) through (8))

The applicable regulation, again in that portion speaking to benefits and limitations, in describing the conditions under which benefits can be extended, states in part that private duty nursing service, "... does not, except incidentally, include services which primarily provide and/or support the essentials

of daily living or acting as a companion or sitter." It further states that, "If the [nursing services] being performed are primarily those which could be rendered by the average adult with minimal instruction and/or supervision, the services would not qualify as covered private duty (special) nursing services regardless of whether performed by an RN, regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient." (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Section C., Subparagraphs 3.n.(4) and 3.n.(5))

The regulation also goes on to state, "It is recognized that even though the care being received is determined to be primarily custodial, an occasional specific skilled nursing service may be required. Where it is determined such skilled nursing services are needed, benefits may be extended for one (1) hour of nursing care per day." (Reference: CHAMPUS Regulation DoD 6010.8-R, Section E, Subparagraphs 12.B.(1) and 12.C.(2).

The appealing parties and their attorneys, submitted or presented statements detailing the factors which, in their view, supported the position that the total services rendered by the private duty nurses were necessary to the proper care of the patient. Nonetheless, it is the finding of the Principal Deputy Assistant Secretary of Defense (Health Affairs) that the Hearing Officer's conclusion was a proper one based on the evidence presented and that his rationale and findings were correct in connection with the private duty nursing services in the home. However, the RECOMMENDED DECISION was deficient to the extent it did not treat the inpatient private duty nursing care rendered in the hospital as a separate issue.

In order to insure that the appealing parties fully understand the bases upon which the initial denial is being upheld, the points raised by the appealing parties are addressed in this FINAL DECISION.

1. Outpatient (Home) Private Duty Nursing: 21 July 1977 through 1 December 1977.

   - o Diagnosis: Esophageal Carcinoma. First it was claimed that due to the patient's diagnosis of esophageal carcinoma, private duty nursing services were required. The available clinical records indicate that during June 1977 the beneficiary/patient was admitted to the hospital where a diagnosis of esophageal carcinoma was

confirmed. The type, stage, exact location or other organ involvement of the malignancy was not revealed, but it would appear that the condition had advanced to the degree that surgical excision was no longer possible. The disease process continued and the patient expired in the hospital approximately 5½ months later. We are not disputing the fact that the beneficiary/ patient had a terminal illness. However, the presence of a serious diagnosis, even a terminal one, is not prima facia evidence that benefits can be authorized for private duty nursing services. In order to be considered for benefits, the specific services rendered by the private duty nurses must qualify as skilled services, i.e., those which can only be provided with the technical proficiency and scientific skills of an R.N. The diagnosis of esophageal carcinoma indicates the beneficiary/patient had a serious illness but in no way attests to the skill level of the nursing services that were provided. (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Section C, Paragraph 3.n.)

o Patient's General Medical Condition. It was next implied that the beneficiary/patient's general medical condition required the constant presence of the private duty nurses in the home. The clinical information in the Hearing File of Record indicates the beneficiary/ patient had surgery for esophageal carcinoma in late June 1977, at which time a gastrostomy tube was surgically implanted into the stomach for the purpose of maintaining an avenue into the alimentary tract for feeding the patient, by-passing the partially obstructed esophogus. She returned to home 21 July 1977. Although requiring rest, she was ambulatory, able to undergo her radiation therapy on an outpatient basis, able to do things around her home, able to visit neighbors and shop, able to go out, for the most part was able to take a liquid or soft diet (in addition to the daily tube feedings), and was mentally competent. The nurses' notes in the Hearing File of Record indicate that initially the beneficiary/ patient was fairly active. As the disease progressed she required stronger and more frequent administration of pain medication as well as becoming less active and requiring more rest. However, there is nothing in the Hearing File of Record, nor was oral testimony presented at the hearing, to indicate she became bedridden at anytime prior to her

return to the hospital on 2 December 1977. Therefore, although there is no question that the beneficiary/patient was seriously ill, that her condition gradually declined and that she was, in fact, terminal; at least for the greater part of the time following her June 1977 surgery she was also an ambulatory, competent and, with limits, functioning person. Rather than supporting the need for the constant attendance of private duty nurses, our review indicated that not even custodial level care was required, at least into October. It appears the beneficiary/patient herself could have seen to her own needs during the early months. (Reference CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C, Paragraph 3.n.)

o Reinsertion of Gastrostromy Tube: Required an RN (or LPN). It was strongly asserted by the spouse that because on occasion the Gastrostomy tube had become dislodged and had to be reinserted, this required the constant attendance of a private duty nurse. The Hearing File of Record indicates the first time this occurred was during the night and discovered in the morning by the spouse before a nurse was on duty. The attending physician advised the patient to apply Vaseline, cover the tube site with a dressing and to visit the emergency room of the local hospital that afternoon for reinsertion. The Hearing File of Record indicates that on at least two subsequent occasions the Gastrostomy tube again dislodged and was reinserted by the nurse on duty. The dislocation of the tube did not represent a crisis or a life-threatening situation to the patient and the attending physician obviously did not view it as an emergency since he did not request that the patient be taken to the hospital immediatley. We do not disagree that reinserting the Gastrostomy tube was a skilled service nor that maintaining the tube in place was important. However, since it was not a crisis incident and could be reinserted at the local hospital or at the physician's office, it would not be appropriate to conclude that private duty nurses should be constantly in attendance in anticipation of this event. That this conclusion is reasonable is supported by the fact that a nurse was maintained for only one shift per day, so apparently the attending physician also did not believe the potential for dislodging the tube was of

sufficient gravity to require the constant attendance of a private duty nurse. (Reference; CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C, Subparagraph 3. n. (8))

o Gastrostomy Tube Feedings: Required an RN (or LPN). The spouse and his attorney also maintained that the beneficiary/patient's need for feeding through the Gastrostomy tube required the presence of a private duty nurse. The tube feedings were usually performed twice daily and consisted of the injection of approximately 1-1/2 to 2 ounces of "Sustacal" (and water) through the Gastrostromy tube. (Contrary to the oral testimony presented by the spouse at the hearing, the nurses' notes in the Hearing File of Record indicate the beneficiary/patient was able to maintain a fairly adequate oral diet, at least through October, and that the tube feedings were essentially supplementary and did not represent the only means of nutrition available to the patient during that time.) Gastrostomy tube feeding is accomplished by filling a syringe with the specified amount of the nutrient substance and slowly injecting it into the tube. Under certain circumstances, this could be part of an array of skilled services. However, with an ambulatory, mentally competent patient, tube feeding of this nature would not require any extensive training or particular skill. It appears it could actually have been adquately performed by the patient herself. The tube site was located on the anterior surface of the abdomen, thus readily available to a patient who had full use of her arms and hands and was rational. There also was no reason the spouse could not have administered the tube feedings although apparently he chose not to. The spouse did give oral testimony that he had been instructed by the hospital staff on how to do this procedure so he could do it for his wife at home. Since we must assume this instruction was done with the approval of the attending physician, it is reasonable to conclude that neither he nor hospital policy considered tube feedings to be a skilled service that could only be done by a nurse. Our findings simply do not support the position that the tube feedings represented a skilled nursing service in this case--i.e., it could have been accomplished by the average adult with minimum instruction and/or supervision. (Reference, CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV Section C, Subparagraph 3.n.(5))

- Dressings at Tube Site: Required an RN (or LPN). It was further maintained that the Gastrostomy tube site required special care and dressings to prevent infection that could only be performed by an RN (or LPN). The clinical information in the Hearing File of Record indicates that drainage of stomach fluids around the insertion site of the tube was fairly constant with the flow increasing as the disease progressed. This drainage caused an excoriation of the skin and topical medications (most often Vaseline) were applied to relieve the skin irritation with dressing changes necessary. The frequency of dressing changes increased as the drainage increased. There was no indication in the nurses' notes that the dressings were applied with any special sterile technique or that the attending physician prescribed such procedures. (Actually, because of the presence of the stomach fluids, use of a sterile technique would not have been particularly effective.) It is also noted that dressing changes were performed by the spouse when the nurses were not present. Further, it would appear that the patient herself should have been capable of managing the dressing changes since she was fully conscious, active, had full use of her arms and hands and the location of the tube site made it fully accessible to her. Our review does not support a finding that the dressing changes at the tube site represented services that could only be performed by an RN (or LPN). (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C, Subparagraph 3.n.(5))

- Overall Episode of Nursing Care: Required an RN (or LPN). It was implied by the spouse that regardless of the specific services rendered, that the constant daily attendance of a private duty nurse was necessary because the overall services provided required the technical proficiency and scientific skills of an RN (or LPN). A review of the daily nursing notes indicated the following services were performed by the nurses in the home:

  - Administration of oral medications: several times daily.

  - Application of topical preparations to the Gastrostomy tube site (primarily Vaseline): several times daily.

- Dressing changes at Gastrostomy tube site--sterile technique nor required: several times daily.

- Tube feedings of 1-1/2 to 2 oz. "Sustacal" and water: twice daily.

- Assisting with enemata: occasional.

- Accompanying patient on visit to doctor's office.

- Accompanying patient for walks, visits to neighbors and to shop.

- General observation.

- Assistance in personal hygiene, bathing, dressing, etc. (although patient was capable of self care at least through October 1977).

- Acting as a companion.

- Reinsertion of Gastostomy tube on at least two occasions.

With the exception of the reinsertion of the Gastrostomy tube and perhaps feeding through the Gastrostomy tube during the latter phase of the disease, none of these services is a skilled nursing service that could only safely be performed by an RN (or LPN). The services are those than can readily be performed by any willing adult with minimum direction or supervision. This is further confirmed by the fact that an RN or LPN was only on duty one shift per day, from 8:00 A.M. to 4:00 P.M. At other times the spouse rendered the same care, except for the tube feedings (which he apparantly chose not to administer) and the reinsertion of the tube which is a skilled service. Further, it would appear that not only the spouse could have performed the required services, but that the patient also should have been able to care for herself during at least July, August and September. Although requiring rest, she was ambulatory, able to go out, able to do things around the home, had full use of her arms and hands and was mentally competent. As the patient's condition declined she no doubt needed some assistance, but it

would appear the presence of her spouse would have been sufficient as it was apparently deemed to be for 16 hours of each day. As indicated previously, the potential need to reinsert the Gastrostomy tube is not sufficiently compelling to categorize the entire episode of nursing as skilled care. In general, the services were those that could have been, and routinely are, performed by the average adult with minimal instruction and supervision. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B.14 and CHAPTER IV, Section C, Subparagraph 3.n.(4) and 3.n.(5))

- Custodial Care. Notwithstanding claims to the contrary by the appealing parties, the clinical information in the Hearing File of Record supports a finding that the disputed home nursing care rendered the beneficiary/patient in this case was primarily custodial in nature. The patient's disability was expected to continue and be prolonged, the nurses created a protected, monitored and controlled invironment for her, the services rendered were primarily supportive, assisting in the essentials of daily living, and the patient was not under any therapeutic regimen which could be expected to reduce the disability. As noted by the Hearing Officer in his RECOMMENDED DECISION, "The beneficiary fits into every portion of the definition of one who is receiving custodial care..." A finding of custodial does not imply the care was not, at least in part, necessary. It simply means that custodial level care does not qualify for benefits under CHAMPVA. However, the evidence in this appeal case does not support the finding that even custodial type care was required by the beneficiary/patient at least into October 1977. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B.46. and CHAPTER IV. Section E., Paragraph 12.a.)

- Offer to Pay for One (1) Hour of Home Nursing Per Day. As indicated above, neither the Hearing File of Record nor the oral testimony presented at the hearing supported a finding that the beneficiary/patient required even custodial level care during July, August and September. Beginning in October 1977, as the patient began a further decline (which it is assumed continued and accelerated into November), it may be that custodial type care was warranted although there is an

equally strong indication that the spouse could have handled the daily needs of his wife without outside assistance, except for reinsertion of the Gastrostomy tube. Nonetheless, and despite these findings, the prior offer to extend CHAMPVA benefits for one (1) hour of nursing care for each day at home private duty nursing care was rendered during the period 21 July 1977 until the patient entered the hospital on 2 December 1977 is not being withdrawn. This FINAL DECISION lets stand the offer made by OCHAMPUS in its First Level Review Decision dated 22 August 1978 and supported by the Hearing Officer's RECOMMENDED DECISION. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section E., subparagraph 12.C.(2))

2. Inpatient (Hospital) Private Duty Nursing: 2 December 1977 through 9 December 1977. The Hearing File of Record contained no written documentation or information relative to the inpatient private duty nursing services rendered the beneficiary/patient from the time she was readmitted to the hospital on 2 December 1977 until her death on 9 December 1977. The Hearing Officer's RECOMMENDED DECISION was silent on this point. It further appears that OCHAMPUS, in rendering its First Level Review decision on the at home private duty nursing, overlooked or was not made aware that eight (8) days of the disputed private duty nursing care was rendered to the beneficiary/patient after she was readmitted to the hospital.

o Requested by Appealing Party. In the oral testimony, the spouse of the beneficiary/patient volunteered that he had requested the attending physician to order private duty nurses because he felt that the hospital nursing staff could not handle his wife's needs. He reported she was in pain and apparently needed restraints and required medications administered intravenously. While it is quite understandable that the appealing party wished to assure that his wife was comfortable and that all her personal needs were met, there was no evidence submitted that would support a finding that the hospital staff nursing could not handle the patient's care. The patient's condition or needs did not present a unique demand in the hospital environment. If a higher level of nursing care had been required, the intensive care unit could have been

utilized. (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Section D, Subparagraph 3.n.(2) and 3.n.(4).)

- o Availability of Intensive Care Unit. At the hearing it was also acknowledge that the hospital to which the beneficiary/patient was readmitted has an intensive care unit. This renders moot all other aspects concerning the inpatient private duty nursing care. CHAMPUS is precluded from extending benefits for inpatient private duty nursing care if the hospital has an ICU, regardless of the circumstances. Therefore, the inpatient private nursing care rendered from 2 December through 9 December, 1977 (when the patient expired) cannot be considered. This determination reverses the implied offer made by OCHAMPUS in its First Level Review Decision, to extend benefits for one (1) hour of nursing care during this inpatient period. (Reference: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Section C, Subparagraph 3.n.(1).)

There was no evidence presented in this case which refuted the basis on which the initial denial determination was made--i.e., that the disputed home nursing care was primarily custodial in nature. In fact, the evidence not only strongly supported a finding of custodial, it also indicated that during the early months not even a custodial level of care appeared to be required by the patient. Further, although the issue was not recognized at other appeal levels, the evidence also indicated the presence of an ICU in the hospital where the inpatient nursing services were rendered, which precluded CHAMPVA consideration of this period of care.

SECONDARY ISSUES

The appealing parties, as well as their attorneys, raised several secondary issues which, it was asserted, supported special consideration to extend benefits in this case.

1. Principle of Estoppel Should Apply. The attorney for the agency that provided the private duty nurses implied that because it took a little over 60 days for the initial determination to be made as to whether CHAMPVA benefits could be extended, that the principle of estoppel should apply. In other words he was, in effect, claiming that the time lapse

between submission of the claim and the denial took so long that the agency had assumed the private duty nursing services were covered by CHAMPVA. First, since CHAMPVA is a Federal Program and the principle of estoppel does not apply to actions of the Federal Government, the issue is moot in this case.

- o However, it should be noted for the record that even if estoppel had applied, the length of time involved in issuing the initial denial was not overly long for a case that required substantial clinical doucmentation and medical review in order for a decision to be reached. Further, benefits cannot be assumed regardless of the time period involved in reaching a decision.

- o It should also be further noted that had estoppel applied, the case still would not have been considered on that basis because the agency failed to submit claims for the ongoing nursing care at least every 30 days as recommended by the applicable regulation. The purpose of recommending early and frequent submission of claims for ongoing care is to avoid whenever possible, or minimize, the impact of retroactive denials. It also simplifies claims review. It is not reasonable to hold back on filing claims for over 90 days then complain that delay in receiving the decision caused an assumption that the care was covered. As to the private duty nursing in this case, there was nothing to preclude the agency from submitting claims to CHAMPVA on a weekly basis in the same manner as the charges were accumulated.

2. Home Nursing Care vs. Hospitalization. The spouse and the attending physician both maintained that the alternative to home nursing care was to keep the patient hospitalized, which would have been much more costly to the Program. We agree: this would have been more costly. However, this conclusion assumes that the prolonged hospital stay would have automatically qualified for CHAMPUS benefits without question. This is not the case. Custodial care is excluded wherever it is rendered, including in a hospital. There was no evidence provided that would have justified keeping the patient in an acute hospital setting and therefore CHAMPUS benefits would not have been available for such an inpatient stay. Further, it is very doubtful that the hospital was actually an available alternative since any hospital utilization committee becoming aware of the type of care being

rendered and the condition of the patient, would soon conclude that the acute setting was not warranted. (In December, when her disease had progressed, she was appropriately readmitted.) Further, benefits are not determined based on a beneficiary or provider's personal consideration of comparative costs. The merits of the individual case, in keeping with law and applicable regulations, is what must be controlling.

3. Sponsor's Disability. The sponsor/spouse advised that he is a 100% disabled veteran from World War II. Only anecdotal information was provided concerning his disability--i.e., that he had back problems and needed a lot of rest. It was implied that due to his disabled condition he was unable to provide for his wife's care. It is noted from the Hearing File of Record and oral testimony that the patient was ambulatory at least through October and did not need lifting. It is further noted that the spouse, despite his disability, was capable of managing his wife's care during the major portion of the day when a nurse was not present. However, this question is essentially moot since the ability or disability of family members is not a consideration in determining the availability of CHAMPVA benefits. Again, benefit decisions must be based on the merits of the case, in keeping with the law and regulations.

4. Attending Physician Acted on Professional Knowledge and Judgment. In an affidavit submitted to the Hearing Officer, the attending physician again asserted that in his judgment the appealing party required the services of the private duty nurses, stating that, "... I had no choice other than to so recommend." This FINAL DECISION in no way questions the attending physician's right to recommend private duty nurses nor that it was or was not appropriate for him to do so, given his knowledge of the personal, social and family circumstances of his patient and her husband. However, we reiterate: Program benefit decisions are based on the application of law and regulation rather than personal circumstances. The available evidence does not support the finding that the care rendered by the nurses was other than custodial--i.e., a level of care which may be appropriate in some circumstances, but for which CHAMPVA benefits are not available.

5. Agency Providing Nurses Acted in Good Faith. The attorney for the agency that provided the private duty nurses stated that the spouse had advised [the agency] that his wife was eligible for CHAMPVA benefits. The attorney implied that because the agency had acted in good faith by providing the private duty nurses, the Program was obligated to extend benefits. This is not an acceptable position. The decision to seek, obtain or provide medical care does not control whether or not benefits can be extended. While it is true that under certain circumstances benefits for private duty nursing services are payable--there are also limitations relating to private duty nursing care. The disputed private duty nursing services in this case fall within those limits and thus are not payable except to the limited extent offered, regardless of any assumption by the provider of care.

6. CHAMPVA Booklet. The appealing parties frequently referred to page 4 of the "CHAMPVA Booklet" as the basis for their position that CHAMPVA benefits are payable for private duty nursing . Although the complete booklet was not submitted in evidence, from the excerpts presented we assume it to be the CHAMPVA Booklet published in 1974 by the Veterans Administration. The purpose of the booklet is informational, providing a general outline of benefits available under CHAMPVA. However, the booklet does not take precedence over applicable law and regulations. For the record, however, let it be noted that while the referenced page 4 does show home nursing care to be a benefit, in that same paragraph nursing care is also specifically related to the concept that it must be essential--which the OASD(HA) review found, at least for the most part, it was not. Further, on that same page 4 it also shows custodial care to be excluded. A Program benefit cannot be viewed in isolation--it must be considered on the basis of all Program provisions, including limits and exclusions.

7. Financial Hardship. The spouse requested administrative consideration on the basis of hardship--i.e., essentially that he had gone ahead and secured the private duty nurses expecting CHAMPVA to cost share. And now that CHAMPVA has denied liability, he has been adversely affected financially. While it is deeply regretted when a Program decision causes financial problems for a beneficiary or sponsor, financial hardship per se is not a valid basis on which to consider an appeal. To assure uniform, unbiased Program decisions,

consideration must be made on the substantive issue(s) as they relate to application of law and regulations.

SUMMARY

This FINAL DECISION in no way implies that the beneficiary/ patient did not personally benefit from the home nursing care rendered by the private duty nurses who attended her. It only confirms that rather than rendering skilled nursing services, the home nursing care was found to be essentially custodial in nature, primarily directed toward providing support and comfort, and assisting in the essentials of daily living. It further confirms that the inpatient private duty nursing care was rendered in a hospital with an intensive care unit, therefore ineligible for benefit consideration under CHAMPVA. The decision to seek private duty nursing care may have been quite appropriate from the personal standpoint of the spouse and the attending physician. However, the disputed private duty nursing services simply do not represent a level of care for which CHAMPVA may extend benefits.

The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in Aurora, Colorado, is directed to make reimbursement for the one (1) hour per day of at home nursing care for the period 21 July through 1 December 1977--a total of 134 days. Based on the information in the Hearing File of Record, for the period 21 July through 6 November 1977, the amount payable is $530.46 (one (1) hour per day for 109 days equals $707.28, less: sponsor's 25% cost share amount of $176.82). The Hearing File of Record does not contain a claim or the provider's itemized charges for the period 7 November through 1 December 1977. Therefore OCHAMPUS is further directed to obtain the necessary documentation from the provider and/or sponsor so an additional payment can be made for the balance of 25 days.

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Our review indicates the appealing parties have been afforded full due process in this appeal. Issuance of this FINAL DECISION is the concluding step in the CHAMPVA appeals process. No further administrative appeal is available.

Vernon McKenzie
Principal Deputy Assistant Secretary
of Defense (Health Affairs)