ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

.ALTH AFFAIRS

22 SEP 1981

FINAL DECISION: OASD (HA) Case File 06-80
[redacted] (Deceased)
[redacted] Spouse, Appealing Party

The Hearing File of Record, the tape of the oral testimony presented at the administrative hearing, the Hearing Officer's RECOMMENDED DECISION and the Memorandum of Nonconcurrence from the Director, OCHAMPUS, on OASD(HA) Appeal Case No. 06-80 have been reviewed. The amount in dispute in this case is approximately $28,600 ($7,651.88 of this amount has been paid by CHAMPUS). It was the Hearing Officer's recommendation that CHAMPUS recognize the propriety of the claims for the patient's care in a skilled nursing facility for the entire period of confinement--29 August 1977 through 26 July 1978. His recommendation did not support the OCHAMPUS decision that the patient's care was primarily custodial and that confinement in a skilled nursing facility was in excess of the appropriate level of care required.

The Director, OCHAMPUS, did not concur with the RECOMMENDED DECISION, finding that the Hearing Officer failed to distinguish care that is custodial from the separate issue of appropriate level of care; or that care may be provided at an appropriate level but still be excluded as being custodial. It was also the Director's position that according to the evidence in the Hearing File of Record, the patient required primarily a controlled and protected environment in which custodial-type care could be rendered, and that no treatment was being provided for the purpose of improving the patient's condition so he could function outside such an environment.

The Acting Assistant Secretary, after due consideration of the evidence and issues in the case, does not accept the Hearing Officer's RECOMMENDED DECISION. It is the finding of the Office of the Assistant Secretary of Defense (Health Affairs) that the Hearing Officer did not reflect proper evaluation of evidence or reasonable interpretation of the applicable regulations.

The FINAL DECISION is, therefore, based on the facts contained in the Hearing File of Record and as presented in oral testimony. This decision confirms the initial denial of CHAMPUS benefits for services and supplies related to the patient's confinement in a skilled nursing facility as being primarily for custodial care

and above the appropriate level of care. Further, it is the Acting Assistant Secretary's finding that the entire stay at the skilled nursing facility, including the first four (4) months, was primarily for custodial purposes and that CHAMPUS benefits were extended in error for this initial period.

The primary issue in dispute in this appeal is whether or not the inpatient care the beneficiary/patient received at a skilled nursing facility was primarily custodial. Related to this issue is the question of whether or not the care could have been rendered in a lower level facility.

The applicable regulation in this case is CHAMPUS Regulation DoD 6010.8-R which defines custodial care as "... care rendered to a patient (a) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (b) who requires a protected, monitored and/or controlled environment whether in an institution or in a home, and (c) who requires assistance to support the essentials of daily living, and (d) who is not under active specific medical or 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 goes on to state, "A custodial care determination is not precluded by the fact that a patient is under the care of a supervising and/or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition and/or provide for the patient's comfort and/or assure the manageability of the patient." (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B.46.; CHAPTER IV, Subsection 12.a.)

The Regulation also describes certain benefits which may be extended in custodial care situations, stating ... "Benefits are payable for otherwise covered prescription drugs, even if prescribed primarily for the purpose of making the person receiving the custodial care manageable in the custodial care environment." And further ... "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." (References: DoD Regulation 6010.8-R, CHAPTER IV, Section E, Subparagraphs 12.c.(1) and 12.c.(2))

The applicable Regulation also speaks to the situation where a beneficiary who is receiving custodial care outside a hospital is admitted or readmitted to a hospital, as follows ... "[Benefits may be extended] When there is an acute exacerbation of the condition [i.e., complications] for which custodial care is being

received which requires active inpatient [hospital] treatment which is otherwise covered." (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section D, Subparagraph 12.d.(2))

In addition, the Regulation specifically excludes custodial care, stating ...."[Excluded is] Custodial Care regardless of where rendered." [emphasis added] (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Subsection G.8)

The applicable Regulation defines "Appropriate Medical Care" [in part] as ..."The medical environment in which the medical services are performed is at the level adequate to provide the required medical care." The Regulation further defines "Essentials of Daily Living" [in part] as "... care which consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and monitoring; safety precautions; general preventive precedures (such as turning to prevent bedsores); passive exercises ..." It also defines skilled nursing services [in part] ... "skilled nursing services are other than 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." (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B.14., B.66. and B.161.)

Also in that part of the Regulation outlining exclusions and limitations, the issue of level of care in excess of the medical needs of the patient or treatment of the condition is addressed, stating ... "Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care [are excluded]." (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Subsection G.3)

The appealing party (the spouse of the deceased beneficiary), her attorney, the attending physician and a staff member of the skilled nursing facility's business office all presented evidence to support the position that the patient's confinement was for active medical care and was not primarily for supportive, custodial-type care. They also maintained that a skilled nursing facility level of care was necessary to monitor and treat the patient's multiple medical conditions. It is nonetheless the finding of the Acting Assistant Secretary of Defense (Health Affairs) that the evidence in the Hearing File of Record supports a finding that the purpose of the admission to the skilled nursing facility was to provide supportive, custodial-type care for a neurologically damaged patient, that the care actually rendered from the date of admission was primarily custodial in nature, and that treatment which was rendered was specifically directed to

secondary complications that resulted <u>after</u> confinement, which could be expected to occur to some degree in all brain damaged, sedentary patients, and which did not require readmission to a hospital in order to be performed.

In order to assure that the appealing party and the other interested parties fully understand the bases upon which the initial denial decision is being affirmed and upheld, each of the points presented is addressed in this FINAL DECISION.

1. <u>Patient's Physical and Mental Condition</u>. The appealing party, her attorney, and the attending physician asserted that the patient had several acute medical and mental conditions which required a substantial amount of care available only in a skilled nursing facility.

   - <u>Onset</u>. The available records confirm that the patient had a history of cardiac problems culminating in a Myocardial Infarction with probable ventricular fibrillation on 27 March 1977. Although emergency procedures were initiated which restored heart action (primarily CPR and defibrillation in the field), the episode resulted in severe brain damage due to anoxia. The records indicated that the patient was initially treated in a civilian facility and after stabilization, was transferred to a Military hospital for continued care.

   - <u>Condition During Confinement in a Military Hospital</u>. The diagnoses on admission to the Military hospital included Atherosclerotic Cardiovascular Disease and Organic Brain Syndrome, secondary to anoxic brain injury during ventricular fibrillation associated with the Myocardial Infarction. A representative of the Military facility certified that the patient was able to take fluids on his own (but required continuous encouragement to do so), required bladder care and monitoring of his cardiac status. During the five month confinement at the Military facility, the patient showed minimal improvement in neurologic function, vocalized with difficulty, could shower with help, but could not care for his own hygienic needs. According to the Hearing File of Record, during the patient's stay in the Military hospital the cardiac problems were brought under control, but the patient's mental disability did not improve. These records also report that the care prescribed at the Military facility was conservative and no specific diagnostic procedures or treatment directed at the Organic Brain Syndrome were conducted. At the time of discharge from the Military facility, the patient's

cardiac status was described as stable and cardiac function was maintained with medication. These discharge records decribed the patient's physical status a "good" but indicated that there was a residual neurological deficit present which continued to interfere with the patient's ability to care for himself on an independent basis.

- <u>Condition Upon Admission to Skilled Nursing Facility</u>. On 29 August 1977, the patient was admitted to a civilian skilled nursing facility, which was capable of providing skilled nursing care and rehabilitation. The report of the physician's initial findings was essentially the same as that provided by the Military facility--i.e., Artherosclerotic Cardiac Disease plus Organic Brain Disorder. It was further reported that the patient was uncooperative and combative. The appealing party's testimony as well as that of the attending physician attempted to direct attention to the patient's cardiac problems which they claimed required constant monitoring, and at electrolyte imbalances which the attending physician claimed could improve the neurological deficits. We note again that at the time of discharge from the Military facility it was reported that the cardiac condition was stable and that the patient's general physical health was good (which would indicate adequate electrolyte balance), but that the neurological deficit continued. Had it not been for the neurological deficit, the Military facility would have released the patient to home once adequate cardiac function was restored and his general condition stabilized. It was the Organic Brain Syndrome which was the basis of the patient's almost five month confinement in the Military facility and for his eventual admission to the skilled nursing care facility--not the cardiac condition.

- <u>Condition While Confined in Skilled Nursing Facility</u>. As described, upon admission to the skilled nursing facility the patient's cardiac condition had stabilized and his physical condition was listed as "good." The patient's mental status, however, was poor--i.e., severe brain damage which resulted from an episode of anoxia. As a result of the Organic Brain Syndrome, the patient was described as uncooperative, combative, unable to adequately follow commands or verbally express himself, as well as having poor bladder control. At the time of admission he was apparently able to get out of bed unassisted, however. Because of the patient's unpredictable behavior, restraints and sedation were instituted

> shortly after his admission to the skilled nursing facility. Initially the patient was able to get the restraints off and move about somewhat on his own. By the second month it appears he no longer removed his restraints and was able to be placed in a chair only with assistance. Secondary problems also began to be experienced by the patient--the types of complications usually associated with the bedridden patient who remains disabled over a long period of time and who, in addition, has central nervous system damage. In this case the problem was no doubt exacerbated because of the use of physical restraints and sedatives to manage the patient. These secondary complications included at various times respiratory distress, urinary tract infections, decubiti, seizures and electrolyte imbalances. The treatment of these secondary conditions was essentially supportive, designed primarily to relieve symptoms and diminish infections. No specific physical therapy program (other than passive exercise) or other specific rehabilative measures were instituted. And no time was it determined that it was necessary to readmit the patient to a hospital to care for these exacerbations in his condition. The patient's mental condition did not improve during his stay at the skilled nursing facility nor was it expected to do so.

That the deceased patient had a history of cardiac problems and suffered a Myocardial Infarction, with an episode of anoxia which resulted in severe brain damage, was never in dispute in this case. At issue is the type of care he required and was being provided. It is clear that the patient's cardiac problems were controlled and that his general physical state of health was stable at the time of admission to the skilled nursing facility. The neurological deficit which resulted from the episode of anoxia and which rendered the patient incapable of self management and unable to care for himself on an independent basis, had continued without improvement, however. It was the Organic Brain Syndrome (and not the cardiac condition) that resulted in the institutional placement--i.e., where he was provided custodial-type supportive care primarily designed to maintain the essentials of daily living. And although after five or six weeks in the skilled nursing facility there began to be a gradual decline in the patient's physical condition due to development of secondary complications, since these exacerbations in the condition receiving custodial care did not require readmission to an acute or special hospital, the case continued to fall within the Program's custodial care exclusion. (References: DoD Regulation 6010.8-R, CHAPTER II, Subsection B.46; CHAPTER IV, Subsection 12.b., and Subparagraph 12.d(2)).

2. Level of Care: Skilled Nursing Facility Required. It was asserted by the appealing party and the attending physician that the deceased patient required, on a constant 24-hour basis, the kind of care and professional skills available only in a skilled nursing facility. It was claimed that the patient's cardiac problems and other conditions required confinement in a setting which could provide active medical care, cardiac monitoring and special observations. The available evidence, however, establishes that the patient's confinement was necessitated not because of the cardiac condition, but rather due to the presence of the Organic Brain Syndrome which had rendered him incapable of independent, self management and which was expected to continue, be prolonged and untreatable. The position that cardiac monitoring and observation of other conditions was the primary basis for this long term confinement is not supported. There was only one electrocardiagram requested during the almost ten month confinement and according to the facility's records this was performed in May 1978. There was no indication cardiac monitoring was prescribed at any other time except that which would occur through routine observation. The records also indicated that electrolyte blood evaluations did not appear to be related to improving the overall mental function as claimed; instead they were performed primarily during episodes of secondary illnesses such as respiratory distress, urinary tract infections and bouts of diarrhea. Contrary to the statements of the appealing party, her attorney and the attending physician, the available evidence in the Hearing File of Record confirms that the prevailing reason for confining the patient in the facility was to provide him with supportive care related to the essentials of daily living and that such care was required because of the Organic Brain Syndrome. The information submitted by the Military facility confirmed that because of the patient's neurological deficit he could no longer "... perform simple personal hygiene duties ..." The physician reported that at the time of the initial evaluation at the skilled care facility, the patient was found to have little bladder control and was "... unable to verbalize or follow simple commands ..." Soon after the confinement at the skilled nursing facility it was noted that the patient refused oral intake and tube feeding was instituted. The records further attest that due to his failure to cooperate, restraints and sedation were necessary. From the time of admission to the skilled care facilty the records confirm that the primary care rendered the patient related to maintaining the essentials of daily living, such as feeding, bathing, ambulating to a chair, maintenance of bowel and bladder function, general monitoring, etc. Further, there was no evidence in the records that would indicate any

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program of rehabilitation or relearning of self-care skills was instituted (although available in a skilled nursing facility). Based on a review of the evidence presented, it is our conclusion that the type of care required by the patient upon admission to the skilled nursing facility was supportive only--i.e., custodial-type care related primarily to the essentials of daily living--and that such care was required because of the Organic Brain Syndrome not the cardiac condition. It is our further conclusion that the required care could have been rendered in a lesser facility, with few exceptions by attendants. The Hearing officer apparently applied some type of criteria used in the State of Florida. These criteria were not made available with the RECOMMENDED DECISION. This is irrelevent, however, because as stated in the OCHAMPUS Memorandum of Nonconcurrence, "These criteria ... neither bind the Department of Defense nor supercede its regulatory provisions." During the last month or so of his life it is possible the patient did require a skilled nursing facility due to the increasing number and frequency of the secondary complications. This discussion is also moot since it has been determined that upon admission to the skilled nursing facility (and at least 60 days prior, while still in the Military hospital) the patient received supportive, custodial-type care and that this would have occurred regardless of the level of institution in which he was placed. And since at no time was it considered necessary for the patient to be readmitted to a hospital in order to care for the secondary complications which developed, the custodial status remained unchanged. It is also our finding that both the outgoing and incoming CHAMPUS Fiscal Intermediaries grossly erred in extending benefits for the initial four months of this stay. The only benefits which should have been provided were for prescription drugs, beginning with the first day of admission and one hour of nursing care per day beginning with the sixth week of his stay. (References: DoD Regulation 6010.8-R, CHAPTER II, Subsections B.14 and B.46 CHAPTER IV, Subsection 12.b, Subparagraphs 12.c(1) and (2) Subparagraph 12.d(2))

3. Skilled Nursing Services Required. The appealing party, her attorney and the attending physician strongly asserted that the patient required skilled nursing care on an ongoing, round-the-clock basis during the entire period he was in the skilled nursing facility.

- Respiratory Problems. About five weeks after admission to the skilled nursing facility the patient experienced his first of several episodes of respiratory infection.

During the first five week period the patient was continuously restrained, ambulation was limited and sedative medication administered, therefore respiratory problems could be anticipated. The therapeutic regimens prescribed for the respiratory distress episodes were antibiotic therapy, oxygen as needed, and postural drainage. Suction was also required periodically. Care of secondary complications was not designed to relieve or reduce the effects of the Organic Brain Syndrome for which the patient was admitted, however. Further, with the possible exception of the suctioning, the therapy required was of a type which can be provided by attendants or other adults with minimum instruction and supervision. Nor did the respiratory care (including the suctioning) require a skilled nursing facility for its performance. It could have been rendered in an intermediate care facility or a nursing home.

- Seizure Problems. Beginning on 15 November 1977 the patient experienced the first of several seizures. It was claimed that monitoring and control of the seizures required the constant presence of professional, scientifically trained nurses. Valium was prescribed for the spasms associated with the seizures. At times, when the seizures appeared to be related to an elevated temperature, Tylenol was also prescribed to reduce the fever and assist in the control of the convulsive movements. Seizure control was generally established without difficulty. The occurrence of the seizure episodes does not, however, support a finding that monitoring for seizures had to be done in a skilled nursing facility by a professional scientifically trained nurse. The "key" to seizure control is having appropriate anticonvulsive medication available to administer at the first indication of a seizure. If a patient is ambulatory and generally functioning, this can be handled on an outpatient basis by a family member. In this case it could have been adequately handled by attendants in an intermediate care facility or nursing home.

- Infections. Urinary tract infections and decubitus ulcers also began to surface during the second month of confinement. As in the case of the other secondary conditions, they required care which continued throughout the confinement. Based on the information in the Hearing File of Record these were never fully resolved inasmuch as the clinical documentation indicates the patient experienced almost a continuous low-grade fever. According to the final summary, it was suspected that the decubiti

had produced a septicemia which was the probable cause of death on 26 July 1977. The management of these conditions, though appropriate and necessary, was primarily through antibiotic therapy, application of topical medications and positioning--none of which require the skill of a professional, scientifically trained nurse.

- Electrolyte Imbalance. The attending physician reported that the patient experienced periodic episodes of electolyte imbalance. It was his position that returning the patient to the proper electrolyte balance could reduce the degree of mental confusion and distress described. The validity of this position was diminished by the fact that this patient arrived at the skilled nursing faciity in a state of "good" physical health (which would include the proper electrolyte balance). Although in some cases proper electrolyte balance may produce some beneficial effect on the mental status of a patient, none was noted or recorded on the clinical record in this case. Again the problems of the electrolyte balance appeared to be primarily related to episodes of diarrhea and the periodic fever problems related to the urinary tract problems. Restoring and maintaining the electrolyte balance was appropriate, but produced no change in the patient's mental status for which the custodial care environemnt was required nor did it require a skilled nursing facility to accomplish.

- Nursing Services Rendered. It was strongly asserted that the kinds of nursing services provided the patient were those which could only be rendered by a professional nurse under the direct supervision of a physician. A review of the clinical documentation indicated that supportive nursing care was provided on a routine basis, as follows:

  - Administration of Medications
  - Application of Topical Ointments
  - Bowel Management
  - Incontinance Care
  - Taking of Vital Signs
  - Positioning
  - Passive Range of Motion Exercises
  - Application of Restraints
  - Placement in Chair
  - Personal Hygiene
  - General Observation & Monitoring

Later in the stay, decubiti care also became part of the routine. In addition, oxygen was periodically administered and suctioning performed during periods of respiratory distress.

The clinical evidence in the Hearing File of Record and the oral testimony does not support the view that the majority of services being rendered represented skilled nursing care that could only be rendered by a scientifically trained, professional nurse. In general, the services provided were those which supported the essentials of daily living and could have been rendered in an intermediate care facility or nursing home environment, in most cases by attendants. It is not an acceptable premise that a patient must be maintained in a skilled nursing facility because general observation is required or because intermittant skilled nursing services are required. Such services may be provided by staffs of lower level facilities or through use of a visiting nurse. Most lower level facilities also have the capability of crisis intervention and there is always the option to transfer to a hospital should acute exacerbation of the condition requiring the custodial care occur. It is our finding that care rendered did not represent ongoing skilled nursing services but rather represented primarily custodial-type care--i.e., supportive services which maintained the essentials of daily living. (References: CHAMPUS Regulation DoD 6010.8-R., CHAPTER II, Subsection B.66 and B.161; CHAMPTER IV, Section E, Paragraphs 12.c.(2) and 12.d.(2))

4. Custodial Care. Notwithstanding claims to the contrary by the appealing party, her attorney and the attending physician, the clinical information in the Hearing File of Record is persuasive and supports the conclusion that the care required and rendered the patient was primarily custodial in nature--not only during the entire stay at the skilled nursing facility but also during at least the last sixty (60) days of the stay in the Military hospital. The Hearing File of Record also confirms that the Organic Brain Syndrome was permanent--i.e., it showed no improvement and was expected to continue and be prolonged; that the purpose of the instutional placement was to provide the patient with a protected, monitored and controlled environment; that the services rendered were designed to provide supportive care, dealing primarily with the essentials of daily living; and that after stablization of the cardiac condition, at no time was the patient placed on a therapeutic regimen which could be expected to reduce his disability to the extent that he could be expected to function outside a protected, monitored and controlled environment. Further, although exacerbation of the condition

requiring custodial care (i.e., secondary complications related to Chronic Brain Syndrome) began to occur about five weeks after placement in the skilled nursing facility, at no time did the care for such conditions require readmission to a hospital--thus at no time did the custodial nature of the case change. It is our further finding that the CHAMPUS Fiscal Intermediaries (both incoming and outgoing) made a gross error in authorizing the initial extension of benefits for the first four (4) months of the inpatient stay. Inpatient benefits should have been denied from the beginning of the stay in the skilled nursing facility on the basis the care being rendered was primarily custodial care--i.e., essentially supportive care related to maintaining the essentials of daily living. (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B.46; CHAPTER IV, Section E, Paragraph 12.a, 12.b, and subparagraphs 12.c. (1) and (2) and 12.d(2))

SECONDARY ISSUES

The appealing party, her attorney and the attending physician raised several secondary issues which they asserted supported special consideration to extend benefits in this case.

1. Veterans Administration Facility. The appealing party reported she inquired about transferring her husband to a Veterans Administration facility when he was still in the Military hospital, but she found the VA waiting list too long and [implied] that this should require that CHAMPUS benefits be extended. There is no documentation of the appealing party's assertion in the Hearing File of Record, but we do not question that there probably was a long waiting list because the patient was a candidate for a VA nursing home (not a hospital). VA nursing homes limit those who are categorized as category I patients to 25% of the caseload, (i.e., patients like the one in this case who require total supportive care to maintain the essentials of daily living). Therefore there is usually an extensive waiting list for placement. This discussion is irrelevant, however. CHAMPUS is a program of financial assistance for covered services/supplies provided under specified circumstances and conditions. It does not directly provide the care nor does it guarantee that care will be available. Therefore, the fact that VA care was not available cannot be used as a basis for providing CHAMPUS benefits. The type of care actually provided and the circumstances involved determines whether or not CHAMPUS benefits can be provided. In this case, the patient received primarily custodial care, which is specifically excluded by law and regulation.

2. <u>Acute Care Setting Would Have Been Required</u>. The attending physician argued that had the patient not been in a skilled nursing facility, he would have required frequent confinements in an acute hospital, possibly involving use of the intensive care unit. He apparently based this position on the secondary complications (i.e., respiratory distress, urinary tract infections, seizures and decubiti) which began to manifest themselves five or six weeks after the patient's admission to the skilled nursing facility. Our review of the Hearing File of Record does not support this assumption. With the possible exception of the initial seizure episode which occurred on 15 November 1977 (on which a Code 99 was called), all of the care rendered to the patient was of a type which could have been handled in an intermediate care facility or nursing home. And even with this type of incident many lower level facilities are equipped to handle such crisis situations or could have called on a public emergency squad. In such incidents once the patient is stabilized, the need for hospitalization usually passes or is very short term. But even if there was a potential for frequent short periods of hospitalization had the patient been placed in an intermediate care facility or nursing home, this would not support long term placement in a skilled nursing facility--at a level above that required to provide the appropriate care. The physician's position that maintaining the patient in a skilled care facility represented some cost saving to the Government is also unsubstantiated and his conclusion, at best, speculative. The discussion is irrelevent, however, since the law and applicable regulations do not give each beneficiary and/or provider the privilege of determining what benefits will be extended based on a personal calculation of savings. Benefit determinations must be based on the level of care required. An arguments based on "savings" to the Government becomes even further irrelevent because custodial care is excluded regardless of where rendered.

3. <u>Financial Hardship</u>. The appealing party requested administrative consideration on the basis of financial hardship. It was her general position that her deceased husband had been placed in the skilled nursing facility with the expectation that CHAMPUS would extend its benefits--and because CHAMPUS had denied liability, she had been adversely affected financially. It is always deeply regretted when a Program decision causes financial difficulties for a Military retiree's family. Financial hardship per se is not, however, a valid basis on which to consider an appeal. To assure uniform, consistent and appropriate Program decisions, appeal decisions must be made on the basis of the substantive issues as they relate to application of law and regulations.

4. Retroactive Denial. The appealing party and her attorney took the position that it is inappropriate to retroactively deny coverage without prior notice. It was pointed out that payment had been made for the first four months of care for the deceased patient's stay at the skilled nursing facility and that it was anticipated such benefits would continue. Except for those few benefits areas which required pre-authorization, all benefit determinations under CHAMPUS are retroactive.[1/] It must be kept in mind that the Program isn't even aware a service or supply has been provided or continued until a claim has been submitted--which is always after the fact. In the case of continued stays or services, each claim stands alone and must be determined on its own merit regardless of whether benefits were previously extended for similar care. Because one claim is paid in a continuing episode of care does not obligate the Program to extend benefits on future claims related to that episode. OCHAMPUS was also in error in referring to a potential "retroactive denial" policy. Various program benefit policies are constantly undergoing review, but this can not be used as a basis of appeal for care already rendered. Before policy changes are made, approval of the Office of the Assistant Secretary of Defense (Health Affairs) is required. If approved, changes are announced both in the Federal Register and through Service media. There has, however, been no change in Program policy related to retroactive denial and therefore as stated by the Director, OCHAMPUS, in his Memorandum of Nonconcurrence, discussion of this matter is not relevant to this appeal.

5. Attending Physician's Viewpoint vs. Peer Review Opinion. The attending physician took the position that the care rendered the deceased patient was not primarily custodial in nature but rather was a level of care that could only be provided in a skilled nursing facility. The attending physician relied solely on his own conclusions and did not present any supporting evidence from other physicians. The appealing party's attorney implied that the weight of evidence should be given to the attending physician's statement and that it should be sufficient for the purpose of extending CHAMPUS benefits. The opinion of the attending physician is always given significant consideration and weight in evaluating an appeal. It is not controlling, however. In this case there was an obvious lack of understanding by the attending physician

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1/ At the time the disputed inpatient stay occurred, the only benefits which required preauthorization were adjunctive dental care and plastic reconstructive and cosmetic surgery under the Basic Program; and all services under the Program for the Handicapped. Any preauthorization that is granted must be for a specific service and time, and must be made in writing.

of the CHAMPUS definition of custodial care. On one hand he stated the care provided the deceased beneficiary was directed at improving the neurological aspects of the patient's condition through maintaining electrolyte balances. In contradiction, he also testified that the Organic Brain Syndrome was expected to be continuous and prolonged and that the care provided the patient was not expected to permit the patient to live outside a protected controlled environment--key elements in any CHAMPUS custodial care determination. The case was submitted to professional peer review by OCHAMPUS before the appeal went to hearing. It was reviewed by a panel of three physicians with specialties in neurology, internal medicine and general practice. It was the conclusion of the reviewing physicians that the care rendered was primarily custodial in nature and that the patient was not under active medical care which would have reduced his disability to the extent that would enable him to function outside the protected environment. The reviewing physicians also concluded that the care rendered could have been adequately provided in a lesser facility. It is our finding that the preponderance of evidence supported the peer review findings.

6. Administrative Problems: Confusion, Delays and Errors. The appealing party and her attorney vigorously complained about the administrative problems encountered in this case. A review of the file indicates they have good reason for their complaints as the case was mishandled and appeared to be the subject of unreasonable confusion, delays and errors. This was compounded by implementation of a new regulation shortly prior to the time the patient in this case was admitted to the skilled nursing facility as well as a change in CHAMPUS Fiscal Intermediaries for the state where the deceased beneficiary received his care. Most of the problems when viewed individually, were minor in nature but admittedly irritating; but when added together were no doubt overwhelming and misleading. Only one incident had any real impact on the case, however. When the current regulation was implemented on 1 June 1977 it contained a provision requiring preauthorization of admissions to a skilled nursing facility. The appealing party on 16 July 1977, apparently aware of this provision, filed a request for approval of benefits in the skilled nursing facility with OCHAMPUS. OCHAMPUS erred by not notifying the appealing party that this provision was not in effect (as permitted under the Regulation's Transitional Authority--See CHAMPUS Interim Instruction 10-77, paragraph B.1., July 6, 1977). Instead the request was forwarded to the CHAMPUS Fiscal Intermediary to handle. The Fiscal Intermediary also erred--not only in failing to notify the appealing party that the preauthorization provision in the regulation

had not been implemented but also in extending benefits for care from admission through 21 October 1977 (it should have been denied as custodial). The new CHAMPUS Fiscal Intermediary compounded the error by further extending benefits through December 1977. While the preauthorization provision was not in effect and therefore technically not an issue in this appeal, the appealing party was never so notified. In view of this confusion and because of the time that has elapsed, even though it has been determined the care rendered the deceased patient was primarily custodial in nature during the entire confinement in the skilled nursing facility, recoupment of the benefits extended through December 1977 will be waived. This in no way implies the custodial care determination is incorrect nor obligates the Program to extend further benefits. It simply waives recoupment of amounts previously paid in error in consideration of the special circumstance identified in this case.

7. Double Coverage. The Hearing File of Record indicates that the deceased patient worked for a bank and that his spouse, the appealing party in this case, worked for a health insurance organization. This would indicate a reasonable probability of double coverage. No where in the Hearing File of Record does it indicate there was any investigation by OCHAMPUS concerning the presence of other coverage--either as an employee through the bank or as a family member through his wife's employment. Before this appeal proceeded, this issue should have been explored and resolved. If the deceased patient was covered through other coverage, since he was a retiree it was required that all his claims be first submitted to the other coverage(s). Before paying for the prescription drugs and one hour of nursing care per day, this issue must be clarified. (References: CHAMPUS Regulation, CHAPTER VIII, Subsection D.1.)

RELATED ISSUE

Stay in Military Hospital. The appealing party complained that she was pressured to remove her husband from the Military hospital where he was confined prior to his transfer to the civilian skilled-nursing facility. It is our finding that transfer should have occurred at least 60 days earlier. The available information confirms that the patient was confined to the Military facility from 8 April 1977 through 29 August 1978, a period of

almost five months. From the information available it would appear the cardiac condition for which the patient was orginally admitted was well stabilized within the first month. The Organic Brain Syndrome resulting from anoxia related to the Myocardial Infarction continued, however. It was appropropriate for the Military facility to retain the patient for a period of 60 to 90 days in order to provide an opportunity for improvement in the neurological deficit to occur. When it did not, and the care being rendered was primarily supportive to maintain the essentials of daily living, it was inappropriate for the Military facility to continue the confinement. In this case the Military facility erred in keeping the patient for a five month period. Transfer should have been effected as soon as it became evident that recovery from the neurological incident was not a reasonable expectation--at least by the 90th day, and more probably at about the 60th day. Military hospitals are acute care facilities and are not to be used to provide long term supportive, custodial-type care.

SUMMARY

This FINAL DECISION in no way implies the deceased patient did not require supportive, custodial-type care--it is clear he did. That the care had to be rendered in a skilled nursing facility is strongly disputed, however. Notwithstanding the level of care issue, this FINAL DECISION confirms the finding that the care rendered the deceased patient in this case was primarily custodial in nature (and was custodial since the time of admission) and was therefore a type of care which does not qualify for CHAMPUS Basic Program benefits.

In keeping with the findings of this FINAL DECISION, subject to benefits not being available from other coverage, OCHAMPUS is directed as follows:

- Waive recoupment of the $7,651.88 in benefits paid in error for the first four (4) months of the stay as permitted under the Claims Collection Act of 1966.

- Extend CHAMPUS benefits for all prescription drugs administered to the patient and for one hour of nursing care per day for the period 1 January 1978 through 26 July 1978.

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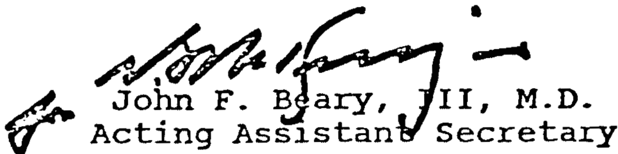
Our review indicates the appealing party has received full due process in her appeal. Issuance of this FINAL DECISION is the concluding step in the CHAMPUS appeal process. No further administrative appeal is available.



John F. Beary, III, M.D.
Acting Assistant Secretary