ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

HEALTH AFFAIRS

28 OCT 1981

FINAL DECISION: OASD(HA) Case File 06-80
Appeal

The Hearing File of Record, the tape of the oral testimony presented at the Administrative Hearing, the Hearing Officer's RECOMMENDED DECISION, along with the Memorandum of [technical] Nonconcurrence from the Acting Director, OCHAMPUS, on OASD(HA) Appeal Case No 06-80 have been reviewed. The amount in dispute in this case is $9,970.65--$7,970.65 for hospital expenses and approximately $2,000 for physician's fees. (CHAMPUS extended benefits for the first thirty (30) days of the hospital care--in the amount of $3,178.96.)

It was the Hearing Officer's recommendation that the initial decision be upheld--i.e., to provide CHAMPUS benefits for the initial thirty (30) day period of inpatient hospital care from 28 September 1977 through 27 October 1977), and to deny CHAMPUS benefits for the balance of the inpatient stay (from 28 October 1977 to 14 December 1977). It was his finding that the evidence presented did not support continuation of confinement in the acute hospital setting after the first thirty (30) days of inpatient care. The Acting Director, OCHAMPUS, while not disagreeing with the recommendation itself, found the Hearing Officers RECOMMENDED DECISION to be technically deficient. It was therefore the Acting Director's recommendation that a FINAL DECISION be issued based on the record.

After review of the documentation and due consideration of the facts and evidence, the Acting Assistant Secretary does not accept the Hearing Officer's RECOMMENDED DECISION nor does he agree with the position of the Acting Director, OCHAMPUS, inasmuch as both limited their comments to the last forty-seven (47) days of the stay rather than reviewing the circumstances of the entire stay. This FINAL DECISION is therefore based on the evidence contained in the Hearing File of Record. It is the finding of the Acting Assistant Secretary that not only was the inpatient care in dispute during the period 28 October 1977 to 14 December 1977 not appropriate (i.e., the last forty-seven (47) days), but that the entire inpatient confinement, including the first thirty (30) days, was medically unnecessary and failed to qualify for CHAMPUS benefits.

PRIMARY ISSUE(S)

The primary matter at issue in this case is whether the inpatient hospital environment was necessary for the patient's condition and/or to perform the medical/psychiatric therapy and whether the hospital constituted an appropriate level of care. If it had been found that an inpatient admission was necessary, a related issue would be the number of inpatient days required.

The applicable regulation in effect at the time the disputed inpatient hospital stay occurred was CHAMPUS Regulation DoD 6010.8-R which defines "medically necessary" as "...the level of services and supplies (i.e., frequency, extent, and kinds) adequate for the diagnosis and treatment of illness or injury ...medically necessary includes the concept of appropriate medical care," (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsection B. 103.)

The Regulation also 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 specifically excludes CHAMPUS benefits for "...Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury." Also excluded are ... "Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care." (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Section B, Paragraph 14 (c); and CHAPTER IV, Subsections G.1. and G.3.)

The appealing parties included the hospital, the attending physician and the beneficiary. (Subsequently, the ex-spouse pursued the appeal as the party responsible for payment of the medical care under a divorce agreement.) All these parties raised issues, made claims and submitted statements, which in their view, supported the position that the inpatient hospital confinement in dispute was medically necessary for the treatment of the patient's condition, and that it was appropriate in its entirety. Nonetheless it is the finding of the Acting Assistant Secretary of Defense (Health Affairs) that inpatient care in a psychiatric hospital setting was neither medically necessary nor an appropriate level of care for the management of the patient or to render her treatment. The outpatient environment could have adequately accommodated the plan of treatment and was appropriate for the patient's condition. It is our further finding that the CHAMPUS Fiscal Intermediary was in error in extending benefits for the first thirty (30) days of the stay--benefits should have been denied the entire confinement.

To be sure the various appealing parties fully understand the bases of the finding that the entire inpatient stay was unnecessary and did not qualify for benefits under CHAMPUS (thus also confirming the initial denial of the inpatient stay beyond the first thirty 30 days), the various issues and the points raised in this appeal are addressed in this FINAL DECISION.

1. Diagnosis: Depressive Neurosis vs. Psychotic Depressive Reaction. The attending physician claimed that although his initial diagnosis was "Depressive Neurosis," subsequent evaluations and information obtained in discussions with the patient indicated that the appropriate diagnosis in this case was "Psychotic Depressive Reaction," a more serious illness than initially indicated. The physician further claimed that the final diagnosis was based on information that the patient experienced hallucinatory and delusional episodes but he did not elaborate on the content of these thought disturbances nor did he indicate their extent nor when the activity occurred--i.e., whether these symptoms occurred prior to admission or during her confinement. Essentially it was the attending physician's claim that the existence of the more serious diagnosis was prima facia evidence that the patient required inpatient confinement in a psychiatric hospital setting. An indepth review of the clinical documentation contained in the Hearing File of Record does not support this position. While a psychological evaluation performed during the first week of the confinement did indicate that there was some evidence that the patient could have some loss of contact with active reality, again no details were provided. The clinical record does not verify any manifestations of disturbed thinking processes, if, in fact, they occurred during the inpatient confinement. There was no mention of the claimed significant symptoms in any of the physician's progress notes nor was there any indication of preoccupation, seclusion, distraction or inappropriate behavior reported in the nursing service records. Despite the notation in the psychologist's report, there were no reports of difficulty with reality. Had the patient actually manifested such symptoms during her hospital stay, it is reasonable to expect that the condition would have been observed and reported somewhere/sometime in the hospital record. Further, there were no precautions or isolation prescribed. Other than the inference contained in the psychologist's report, the hospital records contained no information on the change in diagnosis until the discharge summary which was produced after the patient left the institution. There is no evidence that the attending psychiatrist initiated any new or different

plan of treatment based on the presence of the alledged more severe symptoms; nor did he stop the patient's out-of-hospital activities. While a diagnosis of Psychotic Depressive Reaction is generally perceived as a more serious condition than Depressive Neurosis, it cannot be considered significant in this appeal. What is at issue is the patient's condition, as supported by the hospital's clinical records, which indicated she was stable and without evidence of overt psychosis. Although the attending physician claimed the patient was more disturbed than first discerned, there is no evidence in the hospital record to indicate severe depression or significant potential for suicide. Therefore, it cannot be concluded that the establishment of a diagnosis of Psychotic Depressive Reaction, in and of itself, confirms the need for the patient's initial admission or her continued confinement after 27 October 1977; or that inpatient care in the acute hospital setting constituted an appropriate level of care. (References: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Subsections G.1 and G.2)

2. Inpatient Psychiatric Confinement: Medical Necessity. All of the appealing parties strongly asserted that the entire hospital confinement was medically necessary to treat the condition for which the patient was admitted, including the period on and after 28 October 1977, the issue in dispute which brought this case to appeal. A review of the evidence made available in the Hearing File of Record, however, indicates the primary issue in this appeal is not whether the stay after 27 October 1977 qualifies for benefits but whether any part of the inpatient stay was necessary and appropriate.

a. Onset: Condition Upon Admission. It was reported the patient was hospitalized at a Military hospital approximately two weeks previous to the onset of the depression which resulted in the disputed inpatient psychiatric stay. The Military hospital confinement was reported to have been for evaluation of migraine headaches but there was no clinical documentation presented indicating the findings, diagnosis or plan of treatment prescribed at that facility. Anecdotal information indicated no physical basis for the headaches was found, however. Subsequent to discharge from the Military hospital and approximately three days prior to admission, to the civilian psychiatric hospital, the patient reported that she began to experience episodes of crying. Other symptoms she reported were insomnia and feelings of helplessness. No specific information as to the extent or

frequency of these symptoms was provided. The hospital records indicated that a history and physical examination, performed the day after admission, was essentially negative except for migraine headaches (by history) and mild hypotension. The mental status evaluation also performed the day after admission described the patient as oriented in all four areas (i.e., time, place, person, situation), coherent, cooperative, relevant and spontaneous. There was no defect in memory reported nor was the judgment or affect noted to be impaired. Intelligence was reported to be at the upper limit of the borderline range of mental retardation. The only negative findings reported on the mental status examination were a lack of insight, psychomotor hypo activity and a depressed mood. The hospital records reported that the initial impression of the attending physician was "Depressive Neurosis." Although the records indicated the symptoms appeared three days prior to hospital admission, there was no indication that a psychiatric consultation or psychological testing was performed prior to admission by either the attending physician or by Military physician. The patient claimed she was evaluated by a Military psychiatrist at a facility other than the one where she was confined for migraine headache and that inpatient psychiatric care was recommended. The Hearing File of Record contained no indication of any consultation between the civilian psychiatrist in this case and a Military psychiatrist, however. It was also reported that the patient had been given Elavil prior to admission, apparently prescribed during her inpatient stay for migraine headache, but the purpose of that drug was not revealed nor was the dosage or frequency at which it was prescribed. From the information made available, and based on a negative psychiatric history, it would appear that on admission the patient presented relatively mild symptomology which would more appropriately have been initially considered for treatment on an outpatient basis. In this case, however, the patient was admitted as a hospital inpatient <u>without even being evaluated by the attending physician</u>, apparently relying solely on information supplied by the husband. The information in the Hearing File of Record relative to the patient's presenting symptoms and the duration of these symptoms did not support a decision to admit the patient --particularly without first reviewing her history and conducting a mental status examination.

b. Condition of Patient During Confinement. The hospital records indicate that the patient remained oriented, coherent and cooperative throughout the confinement. Although she was reported to be somewhat tearful and apprehensive about the admission, there was nothing in the hospital record that would indicate she had any problem adjusting to the hospital environment or that she presented any difficulties in management. In fact, the available evidence indicated the patient adjusted very quickly to the hospital environment--to such an extent that the Activities Director expressed concern about her becoming "instutionalized." The records reported that the patient was able to take her meals in the cafeteria, socialize and have phone and visiting privileges almost immediately after admission. There was no indication that the patient was distracted, preoccupied, or inappropriate at any time. When passes were permitted beginning with a restaurant visit on 9 October, there were no reports of problems away from the hospital environment. The only negative information concerning the patient's mental condition during the confinement which appears in the hospital documentation revealed that the patient was irritated by her children's demands while she was on pass at home and that she had difficulty in "closeness" with her spouse. The available records did not, however, indicate that these complaints produced additional symptoms which indicated a worsening of the depression. The documentation in the Hearing File of Record indicated that the patient's condition was essentially stable upon admission and that she remained stable and functioning on an adequate level throughout the hospital stay. The patient's stability was evidenced by the fact that she was able to leave the hospital setting on an almost daily basis, with the approval of her attending physician. In fact, the records show she appeared to use the hospital environment more as an alternative social and living arrangement rather than as a place of treatment. The available information does not establish that the patient's condition required confinement in the acute psychiatric hospital setting--not only during the period 28 October 1977 to 14 December 1977 which was in dispute and brought this case to appeal, but that she did not require the inpatient environment at all, including the initial thirty (30) days as well.

c. Treatment Plan. The treatment plan as presented in the hospital record consisted primarily of extensive chemotherapy including Artane, Mellaril, Benadryl, Sinequan and Dalmane plus other drugs, all administered orally. Adjunctive therapies listed in the hospital documentation included occupational therapy and recreational activities. One episode of psychological testing was also prescribed. No group interactive or family therapy was ordered. Nor do the records indicate individual psychotherapy was ordered although the attending physician claimed he did have private discussions with the patient. (The hospital records note visits by the attending physician but do not indicate the time spent with the patient nor that the visits were for the purpose of rendering individual psychotherapy.) This initial plan of treatment was maintained throughout the confinement except for routine adjustments in medications and dosages. All of the services rendered to the patient were of a type that could have been and routinely are rendered outside the hospital setting. Since in this case, group and other forms of interactive therapy were not prescribed, there would appear to have been little benefit to the patient from a treatment standpoint in maintaining her in the hospital environment. A need to initiate the plan of treatment in the acute hospital setting was not apparent from the records made available for review.

d. Hospital Course. The available documentation indicated that the patient made a very quick initial adjustment to the hospital environment and except for minor complaints such as headaches and a little nervousness, progressed through the first thirty (30) days of inpatient hospital care without incident. The medications were continued and the dosages were adjusted in accordance with the patient's reactions. The hospital records indicated that while the attending physician apparently visited the patient on a daily basis (except for week-ends), he recorded only infrequently in the hospital record, and those notations he did make contained very little information concerning the patient's mental status, symtomatology or other observations obtained during his visits with the patient. In terms of her mental status there was no indication in the hospital record indicating that the patient regressed from the initial level of stability, developed additional symptoms, had any episodes of severe depression or elation or suffered from any hallu-

cinatory or delusional episodes. The hospital course was essentially uneventful except that the patient developed an attachment to a male patient in mid-November which it is assumed was terminated with his discharge. This relationship apparently was not considered significant at the time, since nothing was done to discourage it. During the first week of December an episode of constipation was reported. The constipation problem was remedied by laxatives and enemata after a rectal and surgical consulation. (Paralytic Ileus and an intestinal obstruction were ruled out at the initial examinations.) Throughout these events related to her physical health, there was no indication that the patient experienced any emotional setback or loss of stability and control. It would appear that the patient's hospital course was relatively benign, without adverse events or crises. Nothing in the patient's record concerning her hospital course supports a need for the inpatient environment.

e. Therapeutic Passes. A review of the documentation presented by the hospital indicated that beginning approximately two weeks after admission the patient was permitted to leave the hospital on overnight passes and as of 25 October 1977 the patient received unrestricted daytime passes. The records confirmed that the patient was out of the hospital on pass during all part of fifty-two (52) days of her seventy-seven (77) day stay, as follows:

October 13	Pass to Beauty Shop
October 14	Evening pass
October 15	Daytime pass
October 19	Daytime pass
October 20	Evening pass
October 21	Afternoon pass/overnight
October 22	Pass until 9:00 P.M.
October 23	Evening pass
October 24	Daytime pass
October 25	Daytime pass
October 26	Daytime pass
October 27	Daytime pass
October 28	Overnight pass
October 29	Day pass to 7:00 P.M.
October 30	All day pass
October 31	Evening pass
November 2	Daytime pass

November 5	Weekend pass
November 6	Pass to 7:30 P.M.
November 7	Day and Evening pass
November 8	Daytime pass
November 9	Day and Evening pass
November 10	Evening pass
November 11	Overnight pass
November 12	Pass until 6:35 P.M.
November 13	Day and Evening pass
November 14	Day and Evening pass
November 15	Day and Evening pass
November 16	Day and Evening pass
November 17	Daytime pass
November 18	Day and Evening pass
November 19	Weekend pass
November 20	Daytime and Evening pass
November 21	Daytime pass
November 22	Evening pass
November 23	Out Day and Evening
November 24	Day and Evening pass
November 25	Day and Evening pass
November 26	Day and Evening pass
November 27	Day pass
November 28	Day and Evening pass
November 29	Daytime pass
November 30	Daytime pass
December 4	Daytime pass
December 5	Day pass to doctor's office
December 6	Day and Evening pass
December 7	Evening pass
December 8	Evening pass
December 9	Evening pass
December 10	Weekend pass
December 12	Pass until 4:40 P.M.
December 13	Evening pass

The attending physician claimed the overall purpose of therapeutic passes is to permit a patient to adjust to life outside the psychiatric hospital to get him/her back into the home, family, work situation. On the other hand the patient claimed the need for her frequent passes was because she had to take care of her youngest child--that she was unable to find a babysitter. We have no argument as to the overall purpose of therapeutic passes but do dispute the frequency and extent of passes in this case--such an adjustment process is not

infinite. That a patient could be routinely released to home for babysitting purposes, however, would put any admission under scrutiny regardless of the extent of symptoms. When a patient is capable of managing out-of hospital activities in a controlled, responsible manner on a frequent, almost daily basis, it immediately raises a question about the need for the admission.

The CHAMPUS benefit for inpatient psychiatric care is not automatic nor unlimited regardless of circumstances. In order for such a stay to qualify for benefits it requires that the patient manifest significant symptomatology of some duration, causing serious dysfunction in the individual's daily life (i.e., work, school, family, etc.) and/or that the patient is considered a threat to himself/herself or society. It is our finding that not only was the symptomatology mild, its duration and extent was limited and the degree of dysfunction was not described or assessed. Further, despite claims of suicidal thoughts, inasmuch as no special precautions were instituted, if suicidal ideation was actually expressed, it apparently was not considered significant. In addition although there were assertions by the attending physician of delusional and hallucinatory episodes, no verification could be found in the clinical record. In view of the lack of previous history of mental problems, the mildness and short duration of symptomatology, the lack of any overt suicidal gestures, and the type of treatment plan prescribed, it would appear that outpatient therapy should have at least been tried before inpatient confinement was initiated. Therefore, despite the assertions to the contrary made by the various appealing parties, it is our conclusion that the circumstances of the patient's entire inpatient psychiatric admission failed to qualify for CHAMPUS benefits and that the Fiscal Intermediary was in error in extending benefits for the first thirty (30) days of the stay--i.e., that the entire stay should have been denied as medically unnecessary and an inappropriate level of care. Because of the period of time that has elasped, however, recoupment action will not be initiated for the amount paid in error for the first thirty (30) days of care. (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsections B.14 and B.103; CHAPTER IV, Subsections G.1 and G.3.)

3. Inpatient Stay on and after 28 October 1977: Medical Necessity. The appealing parties claimed the psychiatric hospital confinement was necessary not only during the first thirty

(30) days but also for the entire stay during the period 28 October 1977 through 14 December 1977--the period which was denied by the CHAMPUS Fiscal Intermediary and which resulted in this appeal. With the finding that the entire confinement did not qualify for benefits, the issue of the stay beyond thirty (30) days is moot. To assure the appealing party received every consideration, however, the case was separately reviewed to determine whether the stay on and after 28 October 1977 would have been been appropriate IF the first thirty (30) days had been found to qualify for benefits.

a. Condition of Patient at 28 October 1977. The information in the Hearing File of Record indicates the patient's major complaints upon admission were headache and tension. After a few days the patient was sociable with others, able to have her meals in the cafeteria, received visits from her husband, had ceased to complain of headaches and was actively participating in occupational therapy. Sleep medication was administered on most nights and sleep patterns, as observed by nurses, reported the patient was asleep during night rounds. During the first thirty (30) days of the hospital confinement, the attending physician recorded progress notes on only eight occasions including the admission note. These physician observations indicated the patient initially appeared to be worried. Thereafter, the physician recorded the patient was "doing fair," "a bit wound up in afternoon," "a little nervous around PM." Medication adjustments were periodically inade. On 17 October 1977 the physician reported that the patient had an overnight pass which went well but ... "children irritated her ..." Subsequent notes by the physician reported episodal nervousness, some breast tenderness (apparently minor and which itself cleared without medical intervention) and morning "blues." During the first thirty (30) days there were no physician reports of adverse episodes, events or reactions. The evidence contained in the Hearing File of Record presented a picture of a patient who was without severe depression and no indication of a potential for suicide. As of 28 October 1981 the patient was in a stable, manageable condition with only mild symptomatology being manifested and had easily adapted to the hospital routine. In fact, she appeared to use the hospital as her alternative living arrangement.

b. Condition of Patient During Period 28 October through 14 December 1977. The available clinical doumentation

relating to the period 28 October through 14 December 1977 was carefully analyzed to determined if any significant mental regression could be noted that would support a decision to continue the confinement beyond 28 October 1977 (i.e., if the first thirty (30) days had been found to qualify for benefits).

- Insomnia. It was claimed the patient continued to suffer from insomnia which required the inpatient stay to be extended. According to the physician's notes, after 28 October the patient on at least two occasions apparently complained about sleeping problems. Contrary to this claim, however, nurses notes recorded during the period of complaint reported the patient was asleep when rounds were conducted through the night. Since sleep patterns in a psychiatric patient are significant nursing observations, it must be assumed that any sleep disturbance, restlessness, insomnia, early morning wakefulness or unusual activity during the nighttime hours would have been carefully recorded in the nursing notes. Therefore, although the symptomatology of insomnia may have been reported by the patient, it could not be verified from the clinical record. Further, even if the claimed insomnia actually existed, it would not require the continued inpatient setting for its resolution. The sleep medication that was prescribed was oral and of a type routinely used on an outpatient basis.

- Adjustment Problems: Passes. It was also asserted that the patient experienced serious and significant adjustment problems during pass situations, primarily the first overnight pass, when she apparently experienced irritation with her children, particularly the youngest. The physician also noted on 31 October that passes seemed to make the patient feel guilty and that she was not yet ready for responsibility. Yet in oral testimony the patient claimed the reason for the frequent passes was to go home and care for her youngest child because she could not get a babysitter--which in contradiction, would tend to indicate not only a strong sense of responsibility was present, but that despite any claimed irritation, she could apparently deal effectively with her youngest child. Further, while noting the "adjustment" problem, the

physician did not limit the granting of passes to the patient. During the period 28 October through 14 December 1977 (47 days) the record shows the patient was on pass on all or part of 40 days. Nor was there any indication the passes resulted in any adverse reactions or regression which required any change in the treatment plan. During this period it appears the patient was essentially using the psychiatric hospital as an alternative social environment and living arrangement, coming and going pretty much on her own.

- Relationship with Male Patient. The clinical records indicated that the patient developed an attachment to a male patient during her confinement. The attending physician claimed that this was a sign of psychosis and thus supported the decision to continue the inpatient stay. Again, there was no indication in the clinical records that the physician found this to be a significant symptom at the time the relationship was ongoing. There was no indication that any effort was made to persuade the patient to stop the relationship or that the patient's plan of treatment or out-of-hospital activities were in any way affected or restricted because of the relationship. The patient was even permitted to participate in out-of-hospital social activities with the male patient. Further, there was no evidence presented that indicated the patient suffered any crisis or regression as a result of her relationship with the male patient or that his discharge caused any abnormal emotional reaction. The available evidence does not support a position that the development of this relationship adversely affected the patient or even that the physician actively discouraged it--it was permitted to continue without intervention until the male patient was discharged. There is absolutely no evidence in the clinical records that supports the physician in his position that the patient's relationship with another patient was a symptom of a psychosis or that it was treated as such during the hospitalization. Such relationships are, in fact, fairly common whenever individuals are placed in close proximity for significant periods of time and occur just as readily in the normal work environment as in the hospital patient environment. If

the physician thought the relationship was having an adverse effect on the patient, it is reasonable to conclude that efforts would have been made to terminate or discourage the relationship.

- Gastrointestinal Complications: A Psychotic Symptom. The clinical documentation made available by the hospital indicated that on or about 1 December 1977, the patient experienced an episode of moderate to severe constipation, abdominal distention and lower abdominal pain. In response to these complaints, the attending physician requested a rectal and surgical consultation. The report of the initial consultant's examination revealed that active bowel sounds were present, thereby ruling out suspected Paralytic Ileus. The results of the abdominal Xray also confirmed that an intestinal obstruction was not present. The clinical records indicated that laxatives and special enemata were prescribed which after a few days resolved the problem. Surgical consultation was also performed and included an endoscopic examination. The consultant submitted a report to the hospital chart indicating that the suspected cause of the intestinal problem was a "Functional Bowel Syndrome." The consulting physicians and the attending physician did not specifically identify the cause of the bowel syndrome, but in oral testimony the attending physician admitted that the intensive chemotherapy may have contributed to the episode of constipation. The patient's constipation was not so severe, however, as to require admission to a hospital had she not already been an inpatient. Such consultations are routinely conducted on an outpatient basis. In fact, the record indicates at least one of these consults was performed in the physician's office--not at the hospital. The possible serious conditions--i.e., Paralylic Ilieus and intestinal obstruction--were ruled out almost immediately. Further, the treatment prescribed to resolve the problem--i.e., laxatives and enemata--does not require confinement in a hospital in order to be performed.

  Apparently, in an effort to support his position that the patient was actively psychotic throughout the confinement, the attending phsyician claimed

that the patient's episode of constipation was a significant sign of psychosis--i.e., that had the patient been in contact with reality, she would have reported the constipation problem sooner. These conclusions were revealed in oral testimony at the hearing. The physician's recorded notes in the hospital chart did not document any suspicion that the constipation was related to a psychosis. Our review rejects this conclusion out-of-hand. If there was any breakdown in responsibility related to the episode of constipation, it was that the patient's bowel function was apparently not being carefully monitored. Inasmuch as an intensive psychochemotherapeutic regimen had been prescribed for this patient, including Artane, Benadryl, Taractan, Mellaril, Sinequan and Dalmane, all of which are known to contribute to constipation, prudent management of this case should have required that information concerning the patient's normal bowel function pattern and whether she was subject to constipation. The patient should not have had to report the lack of bowel function--this should have been clinically noted on a daily basis and any diminishing of function immediately reported to the physician. The constipation episode appears to have resulted from a failure of the physician and hospital staff to properly monitor a patient who was known to be receiving multiple medications known to cause constipation. (It is also noted for the record that the plan of treatment in this case--i.e., the use of multiple anticolinergic drugs--was of serious concern to several of the physicians who conducted peer reviews.) The physician's claim notwithstanding, the hospital records do not support a conclusion that the constipation was a sign of psychosis or that the physician reacted to its onset as such. Further, there was no evidence that that any more intensive therapy, other than laxatives and enemas, was recommended or initiated due to the constipation problem. Based on the evidence available it cannot be concluded that the episode of constipation represented evidence of a regression of the patient's mental condition which made the inpatient hospital care medically necessary or required continued confinement in the psychiatric facility for treatment.

Even if the initial thirty (30) days of the disputed inpatient stay had been found to qualify for benefits, in order for further benefits to be extended would require a determination of the continued medical need for the psychiatric inpatient hospital environment. In this case it is clearly established that the continued inpatient setting was not required for either the patients' condition nor the treatment she received. She was stable and free to come and go pretty much as she pleased. Symptomatology was mild and the physical complications related to constipation did not require the hospital environment for its treatment. It is our finding therefore that even if it had been found that benefits were correctly extended for the first thirty (30) days of care, the continued inpatient environment on and after 28 October 1977 was not medical necessary nor did it represent an appropriate level of care. (References: CHAMPUS Regulation 6010.8R, CHAPTER II, Subsections B.14 and B. 103; CHAPTER IV, Subsection G.1. and G.3.)

4. Sexual Dysfunction. It was orally reported at the hearing by the attending physician that the patient had revealed a deep-seated sexual dysfunction with related hallucinatory and delusional episodes. In fact, it was implied that this was the primary cause of the patient's mental problems and had resulted in the patient being unable to attain sexual closeness with her husband. The physician declined to provide any further information concerning the nature of the patient's sexual problem, describing the information as too sensitive to be made a part of the patients' clinical record. Further, he chose not to avail himself of the opportunity to present a separate statement to the OCHAMPUS Medical Director or the Hearing Officer, in order to substantiate this claim. Nonetheless the attending physician maintained the sexual dysfunction was evidence of the patient's psychosis. Except for one mention by the clinical psychologist that the patient's tests had indicated a sexual preoccupation, the clinical record is silent on any specifics concerning sexual dysfunction or any related hallucinatory or delusional episodes. Neither does it indicate any conjoint therapy or individual therapy for the husband was prescribed, which might have been designed to remedy the alledged problem. The initial admission and extended confinement of the patient on the basis of sexual dysfunction cannot be supported inasmuch as it cannot be verified that the sexual problems actually existed, let alone that they resulted in the degree of impairment which would make confinement in a psychiatric hospital medically necessary. Further, if as claimed by the attending physician

the sexual dysfunction was the underlying cause for the admission and continued inpatient confinement, it is pointed out that the Defense Appropriations Act for FY78, in effect at the time the disputed stay occurred, precluded the extension of benefits for any treatment related to sexual dysfunction. Therefore, even if the claimed sexual dysfunction could have been verified as the primary problem, CHAMPUS benefits would not have been available since services and supplies related to treatment of sexual dysfunction/sexual inadequacy is specifically precluded by law. (Reference: (P.L. 95-111, Section 844, Defense Appropriations Act for FY78).

5. Medical Necessity: Appropriate Level of Care. Notwithstanding the strong claims to the contrary by the various appealing parties, the clinical information (or lack thereof) in the Hearing File of Record is overwhelming persuasive and mandates the conclusion that the inpatient psychiatric hospital setting was not medically necessary for the patient's symptomatology or for the plan of treatment prescribed; nor was it the appropriate level of care inasmuch as the outpatient environment would have been adequate. The patient's symptomalology was mild and of short duration. While the degree of dysfunction suffered by the patient was not described, it must be assumed that due to the mildness of the symptoms and their short duration, significant dysfunction could not have yet manifested itself at the time the decision was made to admit the patient to the psychiatric hospital. It was also asserted the patient had expressed suicidal ideation, but this could not be supported as there was no indication of any precautions being ordered, or concern expressed relative to possible suicidal actions. The attending physician also claimed serious sexual dysfunction with delusional and hallucinatory behavior. But here again, except for a single mention by the testing psychologist of the possibility that the patient might be out of touch with reality, and the one test indicating some sexual preoccupation, there was nothing in the clinical record to support this claim. It is therefore our finding that based on the available clinical documentation, the inpatient psychiatric environment was not medically necessary for the condition of the patient nor for the treatment plan prescribed. It is our further finding that the CHAMPUS Fiscal Intermediary should have denied the entire inpatient stay and that extension of inpatient benefits for the first thirty (30) days was in error. As stated above because of the period of time that has elasped, action to recoup the erroneous payment

will not be initiated. (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsections B.14 and B.103; CHAPTER IV, Subsections G.1. and G.3.)

SECONDARY ISSUES

Many secondary issues surfaced during the course of this appeal, several of which the appealing parties asserted supported special consideration for CHAMPUS benefits.

1. Confidentiality. It was asserted by the attending physician that in the interest of confidentiality he had not inserted in the patient's record information of a sensitive nature related to sexual dysfunction. He further declined to provide the information privately and separately. He maintained, however, that had this sensitive information been available, there would be no doubt of the serious nature of the patient's mental problems or her need for the entire inpatient hospital stay, and implying CHAMPUS benefits should be provided on the basis of his general oral statement. Patients have a right to elect not to release personal or medical information to CHAMPUS. In so doing, however, they run the risk of having the affected claims denied. CHAMPUS is required to obtain whatever information and clinical documentation is necessary in order that a complete case review can be conducted. Where particularly sensitive information is involved, a physician may request that it kept from the public record and this is scrupulously honored. In this case the attending physician could have submitted a separate private report to the OCHAMPUS Medical Director detailing the sensitive information which be claimed had not been inserted into the clinical record, but he chose not to do so. (The beneficiary/patient and her sponsor were both present at the hearing, so they were aware that the attending physician claimed that critical information was being withheld and therefore was not available in conducting the review of this case.) The Program is obligated, as stewards of the public's money, to assure that CHAMPUS benefits are extended only for authorized, medically necessary services and supplies provided at the appropriate level of care. This becomes particularly critical in a Program such as CHAMPUS where the benefit structure is generally based on medical necessity rather than on arbitrary time or dollar limits. To exercise this stewardship requires complete information and clinical documentation, whether or not certain elements may be of a sensitive nature--i.e., the Program is responsible for seeing

that the public's funds are properly and wisely spent. In recognition of the patient's right to privacy and the confidential nature of personal and medical information, the Program follows procedures to assure such information remains private and confidential, and has an enviable record in this area. This discussion is essentially moot, however, since confidentiality, while a right to be exercised by the physician or patient, cannot be used a basis for claiming benefits where the need for the care has not been substantiated. It is our finding that the physician and patient in this case failed to provide needed information--i.e., did not fulfill the burden of evidence requirements--which leaves no choice but to promulgate the finding that not only the inpatient stay on and after 28 October 1977 did not qualify for benefits but that the entire confinement (including the first thirty (30) days) was medically unnecessary and represented an inappropriate level of care. (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER II, Subsections B.14 and B.103; CHAPTER IV, Subsection A.5 and Subsections G.1 and G.3; CHAPTER X, Section F, Paragraph 16.i)

2. Referral by Military Physician. At the hearing the patient claimed to have been evaluated by a Military psychiatrist and specifically referred to the private psychiatric hospital with a recommendation for inpatient treatment. It was implied this should qualify the case for CHAMPUS benefits. First, there is nothing in Hearing File of Record which verifies or in anyway supports this claim nor any indication that there was any contact between the attending physician and any Military physician. In fact, the attending physician claimed the admission was based on information provided by the patient's spouse. Although the patient's comments at the hearing were brief, it is assumed what she was actually referring to was the procedure for requesting and obtaining a Certificate of Nonavailability (CNA) which is required for those who contemplate nonemergency inpatient care and who reside within 40-miles of a Military hospital. If one is not issued, claims for nonemergency inpatient care in a civilian hospital cannot be considered for CHAMPUS benefits. If the requested inpatient care cannot be provided by the Military facility, a CNA is issued. Issuance of the CNA, in and of itself, does not constitute a direct referral to a civilian provider or authorization of CHAMPUS benefits, however. It simply indicates that the type of inpatient care being requested or recommended is not available at that Military facility at that particular time. Since this in no way obligated CHAMPUS, issuance of a CNA has no relevance in this appeal.

3. Later Similar Admissions Paid. The various appealing parties pointed out that the patient had had subsequent periods of inpatient psychiatric hospitalization which they contended were paid without question by CHAMPUS including one six week stay. (Apparently at least one of the subsequent inpatient stays was in the some civilian psychiatric hospital involved in this appeal.) Although no specific details concerning the subsequent hospitalizations were provided it was asserted that the extension of benefits for these subsequent inpatient stays supported payment of the stay in dispute in this appeal. It may well be that the patient in this case has a recurring type depressive illness and that continuing or periodic care has been or will be required--perhaps even inpatient care. This fact, however, in no way affects the matter in dispute in this appeal, inasmuch as each incident of inpatient care is reviewed on its own merits. It was the finding of this office that the entire inpatient confinement during the period 26 September through 14 December 1977 stay was medically unnecessary and an inappropriate level of care and this is not altered by any benefits which may had been extended for subsequent inpatient stays. As a matter of fact, the findings in this case raise serious question about the necessity and appropriateness of the later episodes of inpatient psychiatric care. Because the period of time that has elasped, however, the subsequent cases will not be reopened for review.

4. Financial Hardship. The spouse requested special considerations on the basis of financial hardship. It was his position that denial of the disputed stay on and after 28 October 1977 had resulted in an adverse financial impact on himself. He claimed this adverse financial impact has been exacerbated by the divorce agreement which he had entered into. It is always deeply regretted when a Program decision causes financial difficulty for a Military member. Financial hardship per se is not, however, a valid basis on which to consider an appeal--and certainly a decision cannot be influenced by a divorce agreement. A divorce is a personal matter between the spouses and in no way imposes a responsibility on the Government. The matter is moot, however, inasmuch as in order to assure uniform, consistent and unbiased appeal decisions, consideration must be made on the basis of the substantive issues as they related to application of law and regulations.

5. Principal of Estoppel Should Apply. It was also generally implied by the appealing parties that because benefits were

extended for the first thirty (30) days of the disputed stay, the Program was obligated to continue to extend benefits for the entire stay--i.e., in effect claiming the principle of estoppel should apply. Essentially the assertion was that because benefits were extended for a part of the stay, CHAMPUS benefits should apply for the entire episode of inpatient confinement without question. This argument is not persuasive. Acceptance of such a position would preclude a correction of an erroneous decision or reviewing various portions of a stay according to varying circumstances. It is presumed that if initial care in a continuing episode was found not to qualify for benefits, but later in the episode the care was found to qualify, CHAMPUS would be expected to extend benefits for the subsequent care (and rightly so). This principle is appropriate, but must work both ways. This discussion is irrelevant, however, since CHAMPUS is a Federal Program and the principle of estoppel does not apply to actions of the Federal Government.

6. Challenge to Peer Review: Second Guessing. The attending physician dismissed the numerous peer review comments as being "long distance chart review" or second quessing. Such a reacton is not unusual when a third party raises questions concerning treatment practices. The opinion of the attending physician is always considered in any case review but it is not necessarily controlling. It is further pointed out that the general medical community has endorsed peer review as the most adequate means of providing information and advice to third party payors concerning medical matters which may be in question. In this particular case it is noted the peer reviewers had serious concerns about the case--particularly the treatment plan and the inadequacy of the clinical documentation. One stated outright the entire inpatient stay should have been questioned. It is our finding that the peer reviewers erred in this case--that based on their findings of seriously inadequate documentation, their recommendations should have been to deny the entire stay.

6. Clinical Documentation: Burden of Evidence: The clinical documentation submitted to the Hearing File of Record in this care was found to be grossly inadequate. There were infrequent and sketchy physician progress notes, lack of meaningful nursing notes, no record of ordering reasonably prudent observations (such as bowel function), etc. In addition, it was claimed the most significant information concerning the patient was purposely omitted from her record. This lack of documentation was also noted by the peer reviewers. Since both the providers and the patient were

aware of the need for detailed clinical records in order to permit review of the appeal, it must be assumed that the information made available constituted the complete record made on the patient's disputed inpatient psychiatric stay. If this assumption is correct, and if the documentation in this case represents the norm for this psychiatric hospital, there is serious question as to whether the Program should continue to recognize this institution as an authorized provider. Very little critical information was made available and many assumptions and findings therefore had to be based on the fact the Hearing File of Record was silent. It is possible this lack of information worked to the detriment of the appealing parties because the burden of proof rests with the appealing parties to present whatsoever evidence is necessary to overcome an inital adverse decision. In this case not only was sufficient evidence to overturn the initial denial not forthcoming, the general paucity of clinical documentation relative to the need for treatment to be accomplished on an inpatient basis contributed to the finding that the entire inpatient stay should have been denied. (References: CHAMPUS Regulation DoD 6010.8-R, CHAPTER X, Section F, Paragraph 16.i)

7. Period of Time in Apeal. The hospital representative complained about the lengthy period of time it took to hold the hearing. Subsequent to the hearing the sponsor has complained about the extensive time it has taken for this FINAL DECISION to be issued. Although there were some extenuating circumstances prior to the hearing involving obtaining legible records, this complaint is legitimate and one which the Department of Defense is aware. Procedural changes now in process of being implemented are designed to overcome these extensive delays on future appeal cases. Notwithstanding the admitted delays in this case, however, it this does not overcome the primary responsibility in an appeal--i.e., to issue a decision which is in compliance with the law and applicable regulations. It is further pointed out that in this particular case the delay worked to the advantage of the appealing parties--because of the lapsed time recoupment of the CHAMPUS payment eroneously extended for the first thirty (30) days was waived and the subsequent inpatient psychiatric cases were not reopened and reviewed (which could have had the potential of further denials).

RELATED ISSUE

Inpatient Stays for Mental Health Reasons: Inadequate Documentation. This appeal case has again surfaced the issue of inadequate clinical documentation related to inpatient stays for psychotherapeutic purposes. Appropriate clinical documentation is required in these types of cases to no less a degree than for any other illness or injury. While inadequate medical records may not be present in every institution providing this type of care, the problem is sufficently prevalent to require follow-up action by OCHAMPUS. Both the specific psychiatric institutional provider in this case, and psychiatric institutional providers generally, must be alerted to the problem of inadequate documentation. It should be pointed out that inadequate records will not only result in denial of an individual case, but can also be the basis for withdrawing CHAMPUS approval as an authorized provider.

SUMMARY

This FINAL DECISION in no way implies the patient did not suffer from mental illness. It only confirms that for the period 28 September through 14 December 1977, the psychiatric hospital inpatient setting did not represent an appropriate level of care --i.e., it was not medically necessary either for the patient's condition or to render the plan of treatment. As previously stated, under usual circumstances recoupment action would be initiated to recover the amount of the CHAMPUS benefits extended in error for the first thirty (30) days of the inpatient stay (i.e., $3,178.96 paid for the period 28 September through 27 October 1977). In view of the length of time since the admission occurred, however, such recoupment is hereby waived as authorized under the provisions of the Claims Correction Act of 1966.

- Although the evidence in the Hearing File of Record did not support the need for the inpatient confinement, it appears that some treatment was necessary. Therefore, CHAMPUS benefits can be provided for any individual psychotherapy rendered by the attending physician, on the basis of outpatient reimbursement limited to two sessions per week (not to exceed one hour per session). Extension of these benefits is subject to obtaining an itemized bill from the attending physician which indicates that individual psychotherapy was, in fact, performed, the specific dates it was performed and the length of each session.

- Additionally, benefits may be extended for the psychological testing performed on 29 September 1977 and the two consults performed on 1 December 1977 and 5 December 1977, as well as any diagnostic studies specifically related to these consultations. Again, benefits are to be calculated on the basis of outpatient reimbursement--not inpatient.

Payment of these additional benefits is subject to a determination that the "outpatient" benefits which can be authorized on this case calculate to more than the erroneous payment made to the hospital for the first thirty (30) days of the stay. In such an event benefits may be extended for any amount due over the amount erroneous payment. If the authorized outpatient benefits do not exceed the amount paid in error, no further benefits are payable as a result of this appeal.

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

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