ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	OASD(HA) File 80-12
Sponsor:	)	
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 80-12 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the minor beneficiary as represented by his father. The appeal involves the denial of inpatient residential treatment provided to the beneficiary after April 30, 1979 on the basis that the care rendered was custodial. The hearing file of record, the tapes of oral testimony and argument presented at the hearing, the Hearing Officer's Recommended Decision and the Analysis and Recommendation of the Director, OCHAMPUS have been reviewed. It is the Hearing Officer's recommendation that OCHAMPUS denial of cost-sharing after April 30, 1979 be upheld. The Hearing Officer found the care to be custodial and excluded from CHAMPUS coverage. The Director, OCHAMPUS, concurs with the Recommended Decision.

The Acting Assistant Secretary of Defense (Health Affairs) after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer to deny CHAMPUS payment after April 30, 1979 and hereby adopts the recommendation of the Hearing Officer, as modified, as the FINAL DECISION. The total amount in dispute is approximately $9,725.00.

The FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) is therefore to deny CHAMPUS cost-sharing of inpatient residential treatment at from April 30, 1979. This decision is based on findings that the care provided was custodial, not medically necessary and inappropriate medical care.

FACTUAL BACKGROUND

The appealing party's father as representative, his mother, the legal representative from a center for handicapped citizens, and professionals associated with the facility providing

residential care gave considerable written and oral statements relating to the minor child's medical, psychiatric and educational history. The record reflects the beneficiary has a long history of emotional problems and learning disabilities beginning with hyperactivity and aggressive behavior at age 3. Also at this age, the beneficiary began self-abusive behavior of biting his arm or hand. This behavior continued at the time of the residential treatment in issue.

Electoencephalograms were performed on the beneficiary at ages 4, 7, 8, 11 and 12 which were reported abnormal, showing seizure patterns. Various drugs were prescribed to control the hyperactivity and seizures including Thorazine, Ritalin, Pexadrine, Haldol, Mysoline, and Mellaril. At the time of admission to , the record reflects the only continuing drug was Prolixin for behavior control.

It was claimed that psychological evaluation at age 4 concluded the beneficiary had limited attention span and although receptive comprehension was present, language and speech were seriously delayed. The beneficiary was enrolled in the at age 4 for sessions three days a week. After approximately six months, enrollment was discontinued by the facility because the patient's behavior reportedly created problems.

At age 5, the beneficiary entered the , a private residential facility for emotionally disturbed children, where he remained in residence from June 1971 to October 1973. Residential care was discontinued when CHAMPUS discontinued funding for special education, but the patient continued to participate in the facility's day program through 1974. The beneficiary's father and mother asserted the facility helped ameliorate the patient's aggressive behavior and temper tantrums during his residence in the facility, but his problems resurfaced once care at the facility ended.

In 1974, at age 10, the beneficiary was enrolled in a special education program in the public schools. It was reported that he was expelled during the first semester because of uncontrolled behavior (severe temper tantrums). He was then enrolled in a private school in from December 1974 through may 1975.

When the sponsor was transferred to the in 1975, the beneficiary was enrolled in the on the for the summer session. Due to his emotional outbursts, however, the beneficiary was requested not to return to the center in the fall.

In the fall of 1975, at age 11, the minor was enrolled in fifth grade in a public elementary school on the and attended special education classes for three years. During this period, his mother was constantly "on call" to remove the child when he had a temper tantrum. Finally, the public school informed the

parents he would not be permitted to return for the 1978-1979 term because of his emotionally disturbed behavior following his throwing a rock at a volunteer on the playground.

Evaluation at a during July 1978 noted thick scarring on the left wrist caused by the patient biting himself in episodes of self abuse, very poor fine motor dexterity, lumbering gait, and a slow response to questions. The evaluation report concluded that the patient was a healthy adolescent, a behavior problem, and had undetermined genetic metabolic disorders with mental retardation and self abuse.

The beneficiary was referred to by a clinical social worker following outpatient therapy for six months. The beneficiary was evaluated by Dr. , clinical psychologist, on April 28, 1978. Dr. assigned a full scale I.Q. of 43 (moderate mental retardation) but questioned the validity of this rating opining the beneficiary's potential was much higher. Dr. found the beneficiary's behavior to appear as a part of a picture of childhood schezophrenia disorder with consequent retardation in intellectual and social development. Dr. further stated:

> "Undoubtedly within a period of a year, he will either show signs of responding .... or it will become clear that his disorder is irreversible requiring setting for custodial management."

On May 10, 1978, the beneficiary was evaluated by Dr. , Child Psychiatrist, who diagnosed childhood schizaphrenia, severe (DSM II 295.88). The psychiatrist reported the patient's behavior was more bizarre when his mother was present and that the patient was more relevant and in better control when he was alone with the psychiatrist. It was the psychiatrist's impression that the patient displayed blocking, incomplete answers, frustration, and significant difficulty in screening intrusive thoughts. Dr. recommended a trial of residential therapy. On July 6, 1978, Dr. , child psychiatrist, also evaluated the beneficiary and recommended a trial of residential treatment for his severe emotional problems.

On June 28, 1978, the sponsor requested CHAMPUS preauthorization for admission of the beneficiary to on August 2, 1978 with a diagnosis of childhood schizaphrenia, severe (295.88). The treatment plan called for milieu to provide structure and control, help at bedtime by taking him to the bathroom, settling him into bed, assist the beneficiary at mealtimes in selecting food and filling his plate, interrupt mumbling, disjointed speech and get him "back on the track", enrollment in the gross motor program, recreation, and assessment for school in 6 months. CHAMPUS claims for the first 120 days of residential treatment were

submitted to and paid by the CHAMPUS fiscal intermediary for Colorado, Mutual of Omaha Insurance Company.

On November 30, 1978, OCHAMPUS notified the sponsor and that the behavior modification, milieu and special education did not qualify as active psychiatric treatment. A request for continuation of payments beyond 120 days, dated February 13, 1979, was submitted to OCHAMPUS by . On March 30, 1979, OCHAMPUS notified the sponsor and that CHAMPUS payments would terminate as of April 30, 1979, because the beneficiary would have received maximum benefits by that date. The sponsor requested reconsideration of that decision on April 10, 1979.

Upon reconsideration OCHAMPUS upheld the earlier decision due to insufficient documentation of medical necessity for further inpatient stay in a residential psychiatric treatment center and because the care rendered was essential custodial "milieu" care. The review indicated that beneficiary's low level of functioning precluded any likelihood that further benefits would be derived from an active psychiatric residential center.

The beneficiary requested Formal Review on June 5, 1979. The Formal Review again denied payment after April 30, 1979 finding the beneficiary's level of retardation would preclude any likelihood that further psychiatric care would lessen his mental illness sufficiently to permit him to perform routine daily activities and function socially outside an inpatient setting.

The sponsor, representing the minor beneficiary, then requested a hearing which was held on June 26, 1980 in Denver, Colorado before , Hearing Officer. Testimony at the Hearing by the sponsor indicated, beginning September 1, 1979, the local school district and the Colorado Department of Welfare assumed all but $400 per month of the cost of residential treatment. The amount in dispute for this period of care therefore totals $5100, the CHAMPUS cost-share of 75% of $400 for seventeen months. Approximately $4,625.00 is in dispute for the period May 1, 1979 through August 31, 1979. The total amount in dispute is therefore approximately $9,725.00.

The Hearing Officer has submitted his Recommended Decision. All prior levels of appeal have been exhausted and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

Custodial Care

Under the CHAMPUS law, 10 U.S.C. 1077(b)(1), custodial care is specifically excluded from CHAMPUS cost-sharing. The CHAMPUS regulation, DoD 6010.8-R, chapter IV, E.12 and chapter IV, G.7, implements the exclusion and defines custodial care as:

> "... that care rendered to a patient (1) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, and/or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical and/or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored and/or controlled environment."

The record in this appeal must be reviewed in light of these four criteria.

- o Mentally or physically disabled and such disability is expected to continue and be prolonged.

There appears to be no dispute of fact regarding the continued and prolonged mental disability of the beneficiary. The record in this appeal clearly documents the mental disability. The beneficiary is moderately retarded with an IQ of 43 as evaluated in April, 1978. Subsequent evaluation in June, 1979 showed no improvement, although, as in the 1978 testing, hope for higer potential was expressed.

The appealing party contends the beneficiary's disorder interferes with his intellectual capability and consequently, improvement in his emotional stability would result in a higher IQ rating. This may be true to some extent; however, the beneficiary is profoundly, developmentally delayed. At age 16, he was opined to be functioning at a second or third grade level. Dr. , clinical psychologist, testified as a witness for the appealing party that the primary cause of the developmental delay was the mental retardation for which he states no psychiatric facility should be so gandiose as to think it could cure. Medical review by a child psychiatrist associated with the American Psychiatric Association found a life-long development disorder and opined it was highly doubtful much progress would be made. Review by an OCHAMPUS Mental Health Team psychiatrist also noted poor prognosis in view of the limited response over years of therapy.

An emotional disability of the beneficiary is also well documented in the record, presently, the diagnosis is childhood schizyphrenia. Previous diagnoses include Organic Brain Syndrome, a biochemical disturbance, developmental delay due to mental retardation. Beginning at age 3, the beneficiary exhibited severe emotional problems such as biting his arm or hand, "temper tantrums", soiling, overactivity, and destructive behavior. These problems continued to a lesser degree during

the residential treatment. Even assuming significant progress in treating his emotional disorder, Dr. opined a supervised setting would be required for the beneficiary indicating a life-long disability.

The Hearing Officer found the beneficiary was disabled and the mental disability was expected to continue and be prolonged. I agree and adopt this finding. The record fully supports that conclusion.

- o Requires a protected, monitored and controlled environment whether in an institution or in the home.

In reviewing the record in this appeal, I must also agree with the Hearing Officer that the beneficiary does require a protected, monitored and controlled environment. The treatment plan at illustrates this fact. A primary objective stated throughout his recorded stay, was to "know where he (beneficiary) is at all times," support at mealtime and bedtime, constant monitoring to prevent destructive behavior, and to reassure the beneficiary he is safe and protected.

Medical review by the American Psychiatric Association opined the profound educational and developmental delay were chronic and institutional support and care were required. The medical witness for the appealing party, Dr. , agreed the beneficiary could be transferred to a group home or to live with his family but "... quite frankly he will need a supervised setting...." Whether this is primarily due to a chronic emotional disorder or the mental retardation, or more likely a combination of both, is not controlling. The inescapable conclusion is that he will need a protected and controlled environment.

- o Assistance to support the essentials of daily living

This criteria is also well documented in the record. The above cited objectives of support at bedtime, help in selecting food at mealtimes, and problems with soiling illustrate that assistance is required. The medical reviewer opined such assistance was required and the hearing officer reached that conclusion also. Again, I must agree and adopt the Hearing Officer's finding on this criteria. I see no evidence in the record such assistance will not continue to be required.

- o Not under active and specific medical, surgical and/or psychiatric treatment which would reduce the disability to the extent necessary to enable the beneficiary to function outside of a protected, monitored and/or controlled environment.

The main contention of the appealing party in this appeal is that the beneficiary was receiving active psychiatric care and not care related solely to mental retardation. While this has

been disputed by OCHAMPUS and is relevent to the issues of medical necessity and appropriate medical care, it is controlling under the custodial criteria only if the active psychiatric care would reduce the disability to the extent necessary for the beneficiary to function outside a protected environment. If the beneficiary is prevented from functioning outside such an environment due to either (or both) mental retardation or an emotional disorder, the care must be found to be custodial.

Review of the record in this appeal reveals no evidence of sufficient progress either in his mental retardation or emotional disorder that will enable him to live outside a protected environment. Some progress is noted in his behavior, e.g. less frequent outbursts, more appropriate responses to outbursts. However, treatment goals and objectives in May, 1979, the most recent in the record, are very similar to those stated at the time of admission in August 1979. That is, primary therapy was milieu - providing a structured environment. As pertaining to the beneficiary, milieu is prehaps best illustrated by objectives of support at meals and bedtime and close observation at all times.

The record reveals the following information regarding treatment. No documentation exists concerning medication provided to assist in treatment of the psychiatric condition; only seizure medication was prescribed. The beneficiary did not begin school at the facility until June, 1979 when he attended one-half hour per day. The initial treatment program did not include individual or group psychotherapy. Weekly individual therapy with a staff social worker apparently began in late 1978 and sessions were increased in frequency to three sessions per week of twenty minutes each in January 1979. The treatment summary for January - March 1979 state issues on which work was continuing as:

"a - Being close without verbalizing
b - How to greet someone
c - Non-verbal interactions (a wink, a wave, a smile to acknowledge another person)
d - Basic anger and compliance responses"

These individual psychotherapy goals appear very basic especially in view of nine months of residential treatment.

Finally in, May, 1979, the treatment summary indicates the beneficiary was beginning to generate the skills being practiced and sessions were changed to twice per week of longer duration. In April, 1980, psychotherapy was terminated.

In view of the very limited objectives and response by the beneficiary, the individual psychotherapy would not reduce this beneficiary's disability to the extent necessary for him to live outside a protected environment. Despite the claims of the beneficiary's progress by the staff of

, the treatment goals and testimony at the hearing indicate even the facility realized a supervised environment will be a life long necessity for the beneficiary.

Medical review by the American Psychiatric Association opined substantial problems with this residential treatment. The reviewing physician opined:

> "I strongly feel that this patient's treatment was primarily custodial and educational. By custodial, I mean that the environment was aimed in many ways at being a protective environment and that the interventions would primarily be aimed at assistance to support the essentials of daily living."
>
> "Treatment progress that I can see are very basic language and behavioral improvements."
>
> "I see no evidence to support the concept that his participation in the treatment program would allow him to function outside of an institutional setting. His profound educational and general developmental delay is chronic. The areas of treatment and improvement in the program are quite limited in regards to his profound illness. Clearly this patient will need chronic institutional support and care."

The peer reviewer found ample documentation in the record of a profound neurological delay, a seizure disorder, severe learning disorder and a severe behavior disorder. Recommendations for a trial of residential treatment would have had support had the beneficiary been much younger (3 - 7 years of age) and not received previous residential and outpatient psychiatric care.

Medical review by a psychiatrist with the OCHAMPUS Mental Health Team found no support for residential treatment due to the very limited response to therapy over the years. The care was opined as no more than custodial "milieu" care.

While the appealing party and his witnesses strongly disagree with the conclusions of the medical reviews, the evidence of record including the testimony on behalf of the appealing party, does not establish the treatment will reduce the beneficiary's disability to the extent necessary to function outside a protected and controlled environment. The Hearing

Officer found the care would not reduce the disabilities and I concur in his finding on this issue.

In summary, the beneficiary is moderately retarded, severely developmentally delayed and has severe emotional disorders. There is no factual dispute on these findings. Previous residential care and psychotherapy had no effect on these disorders. Because of the multitude of problems, there appears to be little hope, if any, the beneficiary will ever be able to function outside a protected and controlled environment. Even the facility recognizes this unfortunate conclusion. While I agree with Dr. that mentally ill individuals have a right to be free of their disorders, I cannot find evidence of record that the residential treatment will accomplish that goal in view of the multiple problems of the beneficiary. Therefore, I find the residential treatment subsequent to April 30, 1979 is custodial care under the above cited regulatory provisions and is excluded from CHAMPUS coverage. Medical review has severely questioned the need for any residential treatment for this beneficiary; however, I find a trial period of residential treatment is reasonable as potentially a final effort to significantly reduce his disabilities. Unfortunately, the beneficiary did not respond with significant improvement. This determination does not imply that custodial care is not necessary in this case; it only means that the care being provided is not a type of care for which CHAMPUS Payments may be made.

Medical Necessity/Appropriate Medical Care

A second major issue in this appeal is whether the residential treatment constitutes medically necessary and appropriate medical care. Paragraph A.1., chapter IV, DoD 6010.8-R, defines the scope of benefits of the CHAMPUS Basic Program as follows:

> "Scope of Benefits. Subject to any and all applicable definitions, conditions, limitations, and/or exclusions specified or enumerated in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury ...."

Specifically excluded from CHAMPUS coverage are all "services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury." (Paragraph G.1., chapter IV, DoD 6010.8-R.)

Medically necessary care is defined in DoD 6010.8-R, chapter II, B.104, as:

> "... the level of services and supplies (that is, frequency, extent and kinds)

> adequate for the diagnosis and treatment of illness or injury,... Medically necessary includes concept of appropriate care."

Appropriate medical care is then defined in DoD 6010.8-R, chapter II, B.14, as:

> "a. That medical care where the medical services performed in the treatment of a disease or injury ... are in keeping with the generally acceptable norm for medical practice in the United States."

More specifically, the issue in this appeal is whether the residential treatment program included an active psychotherapeutic approach adequate for the beneficiary's multiple disorders and whether that approach was in keeping with the generally accepted norm for medical practice.

The record reveals the primary mode of treatment was milieu therapy providing a protected and structured environment for the beneficiary. Milieu is an important component in inpatient treatment programs; however, in and of itself, milieu is not active psychotherapy and would not reduce the beneficiary's mental disorder.

No medications were prescribed to control the beneficiary's behavior. Psychotherapy was conducted by a staff social worker beginning once per week increasing in frequency later in the treatment program, ending in April 1980. There is no evidence a psychologist or psychiatrist conducted therapy with the beneficiary. The treatment summaries provided by the social worker indicate the therapy concentrated on very basic behavioral teaching and modeling i.e. how to greet someone.

Medical review by a psychiatrist associated with the American Psychiatric Association opined most individuals in the field of child psychiatry would view the beneficiary's illness as primarily neurological with multiple handicaps and not a psychological illness in the sense the developmental delay and maladaptic behavior was a defense against his anxiety. The reviewing psychiatrist further opined the beneficiary's handicaps are relatively fixed and would be most responsive to special educational, behavioral management and medication management, concluding:

> "Few people would support an active, intensive, psychotherapeutic intervention except on a very limited trial basis, early in his development...."

The very limited gains in the initial phases of the beneficiary's current residential treatment are cited in support of the reviewer's opinion. As noted above, the Mental

Health Team psychiatrist disagreed entirely with the residential treatment citing the failure of past intensive interventions. Dr. , staff child psychiatrist at , recommended a trial of residential therapy in May, 1978. Subsequent evaluations in February, 1979 are silent on the beneficiary's progress.

The appealing party and his witnesses disagreed with the medical review opinions and insist an active psychotheraputic approach was the treatment of choice. I note that, despite the fervent disagreement, neither the appealing party nor furnished documentation of an independent medical review supporting their positions.

Following my review of the record, I find little evidence supporting residential treatment subsequent to April 30, 1979. If the beneficiary was responding to the therapy, the progress was extremely slow. Only basic behavioral improvement was noted i.e. less frequent outbursts. After thirty months of residential treatment at the time of the hearing one would expect more definitive progress if the treatment was in fact the appropriate form of treatment. In addition, the beneficiary's history includes previcus attempts at residential treatment which were apparently unsuccessful.

Medical review by independant physicians disagreed with residential treatment in view of the past failure of active psychotherapy and the multiple disorders present. An intensive psychotherapeutic approach was opined to have little impact on the beneficiary's progress or prognosis. The medical reviewers found the target symptoms of residential treatment dealt with issues of close supervision, non verbal interactions, being able to feed himself, etc. None of which were active psychotherapeutic interventions, but were opined to be an excellant behavioral oriented special educational approach to the profoundly developmental delayed and mentally retarded. The interventions were primarily behavioral to deal with the beneficiary maladjustment and behavioral problems. In view of the medical review opinions, lack of sufficient progress and the beneficiary's history, I must conclude residential treatment of active psychotherapy would be of little benefit in combating the beneficiary's multiple problems. The residential treatment is therefore determined not to be medically necessary nor appropriate subsequent to April 30, 1979.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is that CHAMPUS cost-sharing of the residential treatment at provided to the beneficiary after April 30, 1979 be denied as the care is found to be custodial, not medically necessary and inappropriate care. The appeal of the beneficiary is therefore denied.

This FINAL DECISION in no way implies the residential treatment did not benefit the beneficiary especially in behavioral modification and special education. I recognize the special needs of the beneficiary in this appeal and the difficulty of the parents, both financially and emotionally, in dealing with the beneficiary's problems. I am constrained however by statutory and regulatory authorities and charged with the responsibility to insure CHAMPUS funds are expended only for authorized benefits. My decision in this appeal is simply that the services do not qualify as authorized benefits. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

John Beary

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