ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

EALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

MAR 2 9 1983

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
	)	OASD(HA) File 80-10
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 80-10 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the sponsor, as the heir at law of the deceased beneficiary. The appeal involves the denial of home private duty nursing services provided the beneficiary from November 22, 1977 through June 28, 1978. The amount in dispute involves billed charges of approximately $6,615.72.

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 Recommended Decision that CHAMPUS cost-sharing of the private duty nursing services be approved from December 5, 1977 to June 28, 1978. The Hearing Officer found these services to be required by the beneficiary and medically necessary. No finding or recommendation was made for the services provided from November 22, 1977 to December 5, 1977. The Director, OCHAMPUS nonconcurs in the Recommended Decision and recommends issuance of a FINAL DECISION by this office denying CHAMPUS cost-sharing for the entire period of care with the exception of one hour of skilled nursing services per day. Under Department of Defense Regulation 6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject the Hearing Officer's Recommended Decision. In the case of rejection, a FINAL DECISION may be issued by the Assistant Secretary of Defense (Health Affairs) based on the appeal record.

The Acting Assistant Secretary of Defense (Health Affairs) after due consideration of the appeal record, nonconcurs in the recommendation of the Hearing Officer and rejects the Recommended Decision as it fails to consider the entire period of care and relevant issues and authorities. The FINAL DECISION is based on the evidence of record.

The FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) is therefore to deny CHAMPUS payment for services provided to the beneficiary by private duty nurses from November 22, 1977 through June 28, 1978 as custodial care and for failing to comply with regulatory criteria for CHAMPUS coverage of private duty nursing services. It is further determined that one hour of private duty nursing services per day will be allowed and cost-shared by CHAMPUS under the custodial care provision of Department of Defense Regulation 6010.8-R.

FACTUAL BACKGROUND

The beneficiary in this appeal, was the female dependent spouse of an active duty member of the U.S. Army. The claims in question involve the intermittent private duty nursing services in the home by registered nurses from the Professional Medical Coverage Corporation from November 22, 1977 through June 28, 1978.

At the time of the beneficiary's death on June 30, 1978, she was 35 years of age. The Hearing File of Record does not contain extensive clinical documentation relating to the medical conditions and treatment required by the beneficiary prior to the period in question, late 1977 and 1978. However, the following information is available from the Hearing File of Record, including the sponsor's testimony.

The beneficiary suffered from severe juvenile diabetes mellitus which existed prior to and at the time of her marriage to the sponsor in 1962. The beneficiary's diabetic condition was difficult to control and, according to the sponsor, hospital confinement was necessary on the average of two to three times a year.

The sponsor dated his wife's decline in health to late 1976 when she became ill with pneumonia. At that time, he stated, she was confined to the hospital for an extended period, became seriously weakened and was unable to ambulate. Physical therapy was performed on an outpatient basis, but her ambulatory abilities remained limited. Records relating to the episode of illness were not submitted or reported in subsequent documentation and no physicians' statements were presented confirming the sponsor's account of the beneficiary's condition.

About October of 1977, the beneficiary consented to have surgery to correct an old knee injury. The date of the injury, the nature of the injury, and how it occured, were not revealed. In a statement dated February 28, 1978, Dr. Donald D. Weir described the condition as "... Right knee has a persistent mediolateral instability with various deformity during weight bearing."

According to the sponsor, surgery to the knee was complicated by an episode of renal failure which required extensive medical management. It was the sponsor's opinion that with the onset of renal failure, the patient began a downhill slide which ultimately resulted in her death. He also stated that his wife's physician advised that the kidney function remained only a small percentage of normal and that dramatic intervention, such as dialysis or kidney transplant, was not recommended due to the patient's general condition. The sponsor further testified that the doctor would not permit the patient to return home unless accompanied by a registered nurse. At that time the doctor advised the sponsor that the patient's life expectancy was no grater than six months.

Available records indicate the patient was returned home under the care of a nurse and remained there from November 22 to November 27, 1977. During that time the diagnosis listed on the claim form was "Severe Diabetic Draining Ulcer of right foot, Tibeal Plateau of Right Knee, Healing but Swelling." in a statement dated November 23, 1977, also indicated the patient had "... a number of severe afflictions ..." but did not specifically outline the diagnosis or plan of treatment recommended.

The sponsor testified that, in late November of 1977, the patient sustained a fall which resulted in a fractured vertebra and required hospitalization. The fractured vertebra was confirmed by in his statement of February 27, 1978, which indicated that a fracture, compression type, of L1 had been sustained. related the fall which resulted in the fracture to severe diabetic neuropathy with prominant loss of sensation in the lower extremities and in the fingers and marked weakness of lower extremity muscles.

statement of February 27, 1978, listed the following conditions as present in the beneficiary:

- o Diabetes Mellitus. described the patient's condition as labile juvenile diabetes treated by a 1600 calorie diabetic diet and NPH insulin daily, usually 20 units.

- o Visual Impairment. indicated that loss of visual capacity was due to diabetic retinopathy with microaneuryms, hemorrhages and exudates in the eye grounds. No special treatment was indicated.

- o Diabetic Nephropathy. This condition was related to the effect of diabetes on the kidney function and was associated with marked proteinuria, prominent edema and azotemia. It was also claimed to be assosciated with fluid and electrolyte imbalance causing alterations in mental status. considered dialysis to improve kidney status but there was no evidence that this was ever instituted. No specific treatment was listed but doses of diuretics were prescribed to reduce edema.

- o Diabetic Neuropathy. Identified by as the cause of the patient's loss of sensation (numbness) in fingers and lower extremities and her inability to ambulate in safety. He further claimed that this condition had resulted in falls which caused fracturing of the vertebra L1 and the right knee. recommended assistance in ambulation.

- o Abscesses. It was claimed that the patient had experienced a series of small abscesses in the left foot which responded to treatment. The specific treatment was not identified by

- o Vascular Insufficiency. indicated that there was vascular insufficiency in the lower extremities but did not indicate specific treatment.

- o Nausea, Vomiting, Diarrhea. It was claimed that the patient was prone to nausea, vomiting and diarrhea and was often anorexic. These conditions were attributed to the autonomic neuropathy and renal impairment. Lomotil for control of diarrhea and Emesert for nausea were prescribed.

- o Profound Hypoglycemia. claimed the patient was subject to aburpt changes in status related to hypoglycemia which required constant supervision.

- o Emotional State. It was reported that the patient was somewhat labile emotionally with impaired judgment and required close supervision. No specific treatment was outlined for this condition.

- o General Conditions. described the patient as anemic, weak, tiring easily, and very limited in general exercise tolerance. It was his opinion that her prognosis was considered very guarded.

The Hearing File of Record contains documents relating only to two hospital confinements, although there appear to have been others. First, there was a confinement from April 16 to May 10, 1976, for treatment of diabetes mellitus associated with advanced diabetic nephropathy, neuropathy, retinopathy, dyspnea and edema. The discharge summary indicates that on

admission the patient was noted to have an enlarged heart with gallop, marked respiratory wheezing, bilateral pleural effusion and general edema.

Lasix didn't produce the desired decrease in retained fluid and therefore, Hygrotin was added as was Digoxin for heart function. At discharge, lungs where reported essentially clear but activity without dysprea was limited. The discharge plan included home nursing care, ambulation by wheel chair only because of severe neuropathy, low salt diabetic diet, insulin, Lasix and Digonin daily with Hygrotin Monday, Wednesday and Friday, plus Lomotil and Emersert. The final diagnoses were: Organic heart disease with congestive failure, pleural effusion and massive edema and diabetes mellitus.

The second hospitalization of record occured on June 28, 1978 and was the final confinement. The final summary indicates that the patient was admitted with pneumonia secondary to uremia due to longstanding diabetes mellitus. The record indicates the patient followed a rapid downhill course with pulmonary congestion, pneumonitis, stupor, coma and death on June 30, 1978.

The beneficiary received private duty home nursing services intermittently between November 22, 1977 and June 28, 1978. These services were ordered by the attending physician due to aburpt changes in the patient's electrolyte balance and her physical and mental impairment. According to the physician. the patient was able to complete only part of her self-care activities and needed considerable assistance with managing household and homemaking tasks. In the absence of private duty nursing care in the home, the physician stated that the patient would require nursing home placement. Finally, the physician stated that the patient's illness was terminal and her incapacity was progressive.

The sponsor testified that the attending physician advised him in 1977 that the beneficiary had approximately six months to live. He further testified that the attending physician discharged the beneficiary to home only upon the condition she would have a full-time nurse.

The record reveals that nurses were present during daytime shifts primarily days when the sponsor was at work. During the remaining time, the sponsor cared for his wife.

The sponsor testified that he had been trained to administer insulin to his wife, test her urine, and take blood pressure, and that he often called the physician regarding his wife's care.

Nurses' notes for the home nursing care were furnished for the record by the Professional Medical Coverage Cooperation. In

general, review of the notes reveal skilled services performed by the nurses were limited, particularly prior to May 1978, and generally consisted of the following:

- o Monitoring Intake and Output. - Measuring or estimating fluid intake and output. Medication altered on the basis of measurement or estimation.

- o Administration of Medication. - Except for insulin, all medications were administered orally or rectally. Insulin injections were given by the nurse and the sponsor when nurses were not on duty.

- o Monitoring of Vital Signs and Observations. - Daily blood pressure readings taken, and observed and reported beneficiary level of consciousness and general condition.

- o Urine Testing. - Urine sugar and acetone were tested usually on a daily basis and at times more frequently. Depending on the results, insulin was adjusted; however, the records indicate this was rare.

- o Physical Therapy. - Range of motion exercises, leg lifts, active and passive strengthening procedures.

- o Personal Care. - Personal grooming including baths, shampoos, hair coloring and curling, back rubs and applying lotion. Assisted beneficiary in applying makeup, dressing and dealing with children. Due to incontinence, diarrhea and vomiting, the nurses assisted in personal care on these occasions. Assistance in ambulation was provided. After the hospitalization in May 1978, it appears the beneficiary was confined to a wheelchair.

Although minor differences exist between documents in the file, nursing records indicate the nurses were in attendance during the following periods:

	Dates of care	Days	Total Hours	Rate/Hour	Charge
1.	November 27 to December 30, 1977	17	135	$6.50	$ 877.50
2.	January 3 to March 26, 1978	50	389	$6.75	2,625.75
3.	March 27 to April 15, 1978	18	143	$6.75	965.25
4.	May 11 to May 20, 1978	9	71	$6.75	479.25

5. May 22 to June 17, 1978	23	181	$6.85	1,239.85
6. June 19 to June 28, 1978	8	62.5	$6.85	428.12
TOTAL	125	971.5		$6,615.72

The record further reveals that only five CHAMPUS claims were filed for the private duty nursing services. One claim in the total amount of $879.50 (including a two dollar discrepancy) was filed for nursing services from November 27 to December 30, 1977. A second claim for services received from January 3 through March 26, 1978, in the amount of $2,625.73 was also filed. These claims were processed by the previous fiscal intermediary for the State of Iowa, Blue Shield of Iowa, with payment issued in the amount of $2,758.71.

Three claims were subsequently filed with the current fiscal intermediary for the State of Iowa, Wisconsin Physicians Service, for nursing services from May 11 through May 20, 1978, May 22 through June 17, 1978, and June 19, 1978 through June 28, 1978. The three claims were for $479.25, $1,229.84 (a ten dollar discrepancy), and $428.12 respectfully. These three claims were denied by the fiscal intermediary except for one hour of skilled nursing care per day. Payments in the total amount of $48.60, $87.68, and $76.02 were made on the claims.

The basis for partial denial of the claims by the fiscal intermediary was that a majority of the care could have been provided by a family member or unskilled attendant. On informal review the fiscal intermediary authorized an additional payment of $27.40.

Following an appeal of OCHAMPUS, medical consultants with the Colorado Foundation for Medical Care reviewed the file. In the opinion of the reviewing physicians, specialists in internal medicine, the care was necessary but most services recorded in the nurses' notes could have been performed by an average adult with minimal instruction or supervision. One hour of nursing care per day was considered appropriate. The reviewing physicians further stated that, in their opinion, the case in question was primarily custodial in nature under CHAMPUS criteria.

The OCHAMPUS review upheld the partial denial of the claims on the basis the care was excluded from CHAMPUS coverage as custodial care. The OCHAMPUS review decision did not address two claims previously paid for services received from November 22, 1977 through March 26, 1978. In addition, no CHAMPUS claim has been received for the nursing services received from March 27, 1978 through April 15, 1978.

A hearing was requested by the sponsor as the surviving spouse and heir of the deceased beneficiary. The appeal file reflects probate of the estate of the beneficiary is not required and therefore no personal representative has been appointed.

The Statement of OCHAMPUS Position submitted prior to the hearing opined there were no apparent differences between the care rendered May 11 through June 28, 1978 and that care rendered prior to March 26, 1978. Therefore, the entire episode of care from November 22, 1977 through June 28, 1978, was challenged at the hearing as excluded under CHAMPUS as custodial care, except for a maximum of one hour of skilled nursing services per day.

The Hearing was held on June 25, 1980 at Cleveland, Ohio before , OCHAMPUS Hearing Officer. The Hearing Officer has issued his Recommended Decision. All levels of administrative appeal have been completed and issuance of a FINAL DECISION is proper. Only the charges for private duty nursing services are in dispute. All other claims and charges relating to the hospitalization, physician charge and prescription drugs are assumed to have been fully paid as the file does not reflect any dispute regarding these potential claims.

ISSUES AND FINDINGS OF FACT

As stated above, it was the OCHAMPUS position at the Hearing that the entire period of care from November 22, 1977 through June 28, 1978 should be in issue in this appeal. The Recommended Decision considered the period of December 5, 1977 to June 28, 1978 to be in issue. While no nursing notes were provided for November 22, 1977 to December 5, 1977, I must assume the services were similar during that period to those from December 5, 1977 through June 28, 1978 as the condition of the beneficiary during this period began to decline. Therefore, I find the proper period in issue is November 22, 1977 through June 26, 1978.

Based on this finding, the primary issues in this appeal are (1) whether the private duty nursing services provided November 22, 1977 through June 28, 1978 were custodial care and (2) whether these services met the specific requirements of Department of Defense Regulation 6010.8-R, the applicable regulation governing CHAMPUS, for authorized private duty nursing?

Custodial Care

Under 10 U.S.C. 1077(b)(1), custodial care is specifically excluded from CHAMPUS cost-sharing. DoD 6010.8-R, chapter IV, E.12 implements this exclusion by providing, in part, as follows:

"12. Custodial Care. The statute under which CHAMPUS operates specifically excludes custodial care. This is a very difficult area to administer. Further, many beneficiaries (and sponsors) misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Definition of Custodial Care. Custodial care is defined to mean 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. 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. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a R.N., L.P.N., or L.V.N.

b. Kinds of Conditions that Can Result in Custodial Care. There is no absolute rule that can be applied. With most conditions there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial

care cases might be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or pre-senile and senile dementia. These conditions do not necessarily result in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling but whether the care being rendered falls within the definition of custodial care.

c. Benefits Available in Connection with a Custodial Care Case. CHAMPUS benefits are not available for services and/or supplies related to a custodial care case (including the supervisory physician's care), with the following specific exceptions:

(1) Prescription Drugs. Benefits are payable for otherwise covered prescription drugs, even if prescribed primarily for the purpose of making the person receiving custodial care manageable in the custodial environment.

(2) Nursing Services: Limited. 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.

(3) Payment for Prescription Drugs and Limited Skilled Nursing Services Does not Affect Custodial Care Determination. The fact that CHAMPUS extends benefits for prescription drugs and limited skilled nursing services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

d. Beneficiary Receiving Custodial Care: Admission to a Hospital. CHAMPUS benefits may be extended for otherwise covered services and/or supplies directly related to a medically necessary admission

to an acute care general or special hospital, under the following circumstances:

(1) Presence of Another Condition. When a beneficiary receiving custodial care requires hospitalization for the treatment of a condition other than the condition for which he or she is receiving custodial care (an example might be a broken leg as a result of a fall); or

(2) Acute Exacerbation of the Condition for Which Custodial Care is Being Received. When there is an acute exacerbation of the condition for which custodial care is being received which requires active inpatient treatment which is otherwise covered.

. . . . "

It is clear that the beneficiary's care meets the four criteria in the CHAMPUS definition of custodial care.

- o Mentally or physically disabled and such disability is expected to continue and be prolonged. The appeal file reflects the beneficiary was physically and perhaps mentally disabled by the multiple, serious and irreversible complications of the primary condition, diabetes mellitus. It would appear that the combination of these degenerative conditions accelerated the patient's deterioration and made management of the primary medical conditions almost impossible.

  The available records further indicate little evidence that the late beneficiary would recover. In fact, the multiple conditions were expected to progress and become more disabling. In his February 27, 1978 statement, outlined the chronic conditions associated with the beneficiary's severe diabetic state and indicated that because of these conditions the beneficiary was substantially impaired in her ability to ambulate, see properly, maintain adequate nutritional and fluid balances, and control the primary diabetic condition.

  Medical opinions from physicians associated with her case opinion reveals her condition was terminal before the nursing care in question was furnished. No evidence was presented that would indicate the beneficiary's decline was expected to cease or that restoration to physical health or function was

anticipated. On the contrary, statement indicates the patient's condition would continue, progress, and eventually result in her death.

- Require a potected, monitored and/or controlled environement whether in an institution or in the home. It was the attending physician's opinion that the beneficiary required close supervision and assistance because of the fact that she had limited visual acuity, difficulty ambulating independently, impaired judgment, and was prone to aburpt changes in her physical status. He stated that without daily nursing care at home and fairly close medical supervision, the patient would require nursing home placement.

  The patient's general condition did not permit her to function outside a controlled and monitored environment and the continuing decline in her health progressed to the degree that ambulation to a wheelchair was the maximum extent of her activity. The available evidence confirms that the beneficiary required assistance and close supervision in the home as an alternative to nursing home confinement.

- Requires assistance to support the essentials of daily living. The attending physician's statement of 27 February 1978 indicates that the patient required assistance in selfcare activities, ambulation, and maintaining adequate oral intake of fluid and nutrition. The nurses' notes indicate that the beneficiary required assistance in bathing, toileting, and general personal care.

  The nurses were also needed to prepare and assist in food and fluid intake, maintain skin care, and assist in dressing. These records also report periodic episodes of incontinence and frequent bouts of vomiting. The evidence establishing the beneficiary's degree of disability would necessarily indicate that her ability for total selfcare was extremely limited and, therefore, support in the essentials of daily living was required. She very clearly required help to support the essentials of daily living; in fact this represents a major portion of the nurses' time.

- 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 available evidence, physician's statements, and very limited hospital records do not confirm that active medical, surgical, or psychiatric treatment designed to reduce the

beneficiary's disability to the extent necessary to enable her to function outside the home environment and without assistance, was instituted. The therapeutic regimen outlined in the physicians' statements indicates that the medical treatment offered was primarily to reduce the discomforting symptoms associated with the diabetic condition and the vascular and neurological complications which occurred.

indicated that the general plan of treatment included daily insulin and a controlled diet, Lomotil to control diarrhea, and Emesert suppositories to relieve nausea. These measures essentially provided relief of symptoms but did not effect a cure of the condition which produced the symptoms. Renal dialysis was listed as a possible consideration for the beneficiary but no evidence was presented that would indicate this was seriously investigated.

In May 1978, the beneficiary was discharged after a three-week hospital confinement. plan of treatment at that time included salt restricted diabetic diet, daily insulin, daily diuretics plus an additional diuretic three times per week to reduce edema, daily Digoxin to improve heart efficiency, and medications to relieve nausea and diarrhea. Again, this plan of treatment was designed to relieve the symptoms related to the complications of the diabetes, and to control the diabetes mellitus and the cardiac disease, but it was not intended or expected to eliminate, or result in the cure of any of, the beneficiary's chronic conditions.

There is no indication that the patient was considered a proper candidate for any surgical procedures to correct vascular problems or renal insufficiency. Further, although some emotional instability was identified by the attending physician, there is no indication that psychiatric treatment was suggested in this case. The available evidence in the Hearing File of Record establishes that, the medical management was directed at controlling the effects of the heart disease, diabetes and other complications, but that there was no active medical, surgical or psychiatric treatment suggested or performed that would have been expected to restore the patient to adequate independent function.

The Colorado Foundation for Medical Care reviewed the case and concluded that the evidence available established the existence of a disability which was expected to continue and be prolonged; that a controlled, supervised environment was required by the patient; that the beneficiary required assistance to support the essentials of daily living; and that

there was no evidence of active medical care designed to reduce the patient's disability. The report of these reviewing physicians confirmed the determination that the beneficiary's private duty nursing care in excess of one hour per day, during the period 22 November 1977 through 28 June 1978, was primarily custodial and therefore, excluded by the CHAMPUS law and Regulation.

Testimony at the hearing does not contradict the custodial nature of the care. The attending physician's statement that home nursing was the only alternative to nursing home care supports the above conclusion. Therefore, I find the private duty nursing services provided November 22, 1977 through June 28, 1978 were custodial and excluded from CHAMPUS coverage.

The Hearing Officer, in his Recommended Decision, listed the issue of custodial care, but neither discussed the criteria nor made a finding on this issue. Despite attempts by OCHAMPUS to correct this erroneous action, the Hearing Officer placed the issues in an "either-or" posture, thereby failing to discuss this relevant (and dispositive) issue. For this primary reason, I have rejected the Recommended Decision.

Pursuant to the above quoted regulatory provision, a maximum of one hour per day may be cost-shared for skilled nursing services in a custodial care case. Due to the serious physical condition of the beneficiary, it is evident occasional skilled nursing services were required. Therefore, I find the maximum of one hour of skilled nursing services per day is allowable. As the record reflects that, prior to March 26, 1978, the charges were paid in full, potential recoupment of the difference between these payments and appropriate payments for one hour of skilled nursing per day must be considered. Therefore, this matter is referred to OCHAMPUS for determination of the correct payment for services in question and consideration of recoupment action if appropriate under the Federal Claims Collection Act.

Private Duty Nursing

Even if the beneficiary's case had not been determined primarily to involve custodial care, the private duty home nursing care would have to meet criteria for CHAMPUS coverage specified in Department of Defense Regulation 6010.8-R. As defined by the Regulation, private (special) nursing services mean:

> "... skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing Registered Nurse (R.N.) or Licensed Practical or Vocational Nurse (L.P.N. or L.V.N.),

> only when the medical condition of the patient requires intensified skilled nursing services (rather than primarily provided the essentials of daily living) and when such skilled nursing care is ordered by the attending physician." (DoD 6010.8-R, chapter II, B.142).

Skilled nursing service is defined as:

> "... a service which can only be furnished by an R.N. (or L.P.N. or L.V.N.), and required to be performed under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. 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." (DoD 6010.8-R, chapter II, B.161.)

The extent of benefits for private duty nursing is specified in DoD 6010.8-R, chapter IV, C.3.o., in part, as follows:

> "Private Duty (Special) Nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to an individual beneficiary/patient requiring intensified skilled nursing care which can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient nor the professional status of the private duty (special) nurse rendering the services.
>
> (1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital which does not have an intensive care unit ....

> (2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.
>
> (3) ....
>
> (4) Private duty (special) nursing care does not, except incidentally, include services which primarily provide and/or support the essentials of daily living, or acting as a companion or sitter.
>
> (5) If the private duty (special) nursing care services being performed are primarily those which could be rendered by the average adult with minimal instruction and/or supervision, the services would not qualify as covered private duty (special) nursing services regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.
>
> ...."

As specified in the above quoted regulatory provision, to qualify for CHAMPUS benefits, the private duty nursing services must be skilled services, not services which primarily provide support for the essentials of daily living or could be performed by an average adult with minimal instruction/supervision. The nurses' notes of record do not reveal that the services provided the beneficiary meet these requirements. As detailed above, services of personal care, ambulation, oral and rectal administration of medication, monitoring of vital signs, and urine testing, for example, could be provided by an average adult and are not of a skilled nature. Injection of medication is normally a skilled service; however, insulin is normally administered by the patient or a member of the family--equating to an average adult. The physical therapy exercises likewise could be performed by an individual with minimal instruction.

Further, the private duty nurses herein were engaged for an eight hour daytime shift corresponding to the sponsor's work schedule. Otherwise, the sponsor provided the care required at which he had been instructed and he maintained some contact with the attending physician during these times. I cannot escape the conclusion that, if the sponsor could provide essentially the same care provided by the nurses, the services were not of a skilled nature. The controlling question, then,

is not who provided the services but did the services require the technical proficiency of a nurse.

Review of the available nurses' notes indicates that the few skilled services actually performed in this case could have been accomplished by the professional nurse within one hour.

- o Monitoring Level of Consciousness. The nurses' notes indicate that the patient became drowsy at times, but there were no reports in the record of loss of consciousness. The records report that the patient was aware of the onset of insulin reactions and would request sugar. She also was aware of her need for additional insulin and requested it when necessary.

- o Monitoring Vital Signs. The observation of vital signs was not recorded on a daily basis until late in March 1978. Thereafter, blood pressure readings were routinely recorded. There is no evidence that very high blood pressure readings were reported to the physician or that he required this. Episodes of shortness of breath were reported to the nurse by the patient beginning on April 10, 1978. This symptom continued and was associated with congestive heart failure.

- o Administration of Medication. Except for insulin, the medications, were generally administered orally or by rectal suppository. Initially, the medication prescribed for the patient consisted of Lomotil to control diarrhea, Emesert suppositories for nausea, and daily insulin. Oral Ampicillin was prescribed during the period 5 through 16 December 1977. Tylenol with codeine was also prescribed and given on an as necessary basis. Lasix was ordered to relieve edema and was given intermittently during the period 5 December 1977 through 15 April 1978 and daily from 10 May through 28 June 1978. Digoxin and Hygrotin were added after 10 May 1978 and continued therafter.

  The records indicate that all of the medications were routinely self-administered or given by the beneficiary's husband. No special observation or monitoring of reactions is routinely necessary with most of the medications prescribed in this case except that urine testing of sugar and acetone is necessary with insulin administration; and pulse rate should be observed before the intake of Digoxin. These observations, can be performed by any person of average ability.

- o Intake/Output. In addition to the routine care, the nurses' notes indicate that measuring of intake and output was recorded and that exercises were performed.

> The intake and output monitoring was continuous but the exercise program was discontinued after the April hospital confinement for congestive heart failure because the patient was no longer able to endure the procedure. The significance of these services would be part of the professional nurse's training, but the actual performance of the tasks could easily be delegated to any average adult.

It is clear from reviewing the nurses' notes submitted in this case that the skilled nursing services required by this patient were limited and probably did not require the technical or educational proficiency of a registered nurse. Most of the services were routinely performed by the husband when the nurses were not present. Certainly there is no evidence that full-time skilled nursing care was necessary. At the most, one hour per day of skilled care would have been adequate to the needs of this patient and it is therefore concluded that benefits should be limited to this amount of time.

The facts that the professional nurses were employed for only one shift; that the patient's care was ongoing throughout the twenty-four (24) hours of each day; and that the patient continued to require observation, medication, and supervision throughout that part of the day when no nurses were present, indicate that much of the care was provided by the appealing party. They also indicate that the small part of the treatment regimen requiring the highly technical and scientific skills of a professional registered nurse (one hour a day at maximum) could have been managed by a visiting nurse.

These is no documentary support for the assertion of the appealing party and the attending physicians that the patient needed "highly technical assistance" available only from R.N.'s. In fact, evidence in the Hearing File of Record indicates that very little of the care required the level of intensified skilled nursing care available only from a professional R.N. It also indicates that most of the care could have been managed by a responsible adult of average ability with a minimum of training.

Peer review opinions by physicians associated with the Colorado Foundation for Medical Care support the conclusion that the claimed services were not skilled nursing care. Periodic visits by a registered nurse were deemed sufficient by the reviewing physicians to monitor the beneficiary's insulin and to make general nursing observations. The care, otherwise, was opined to be mostly attendant care not requiring the technical proficiency and skills of a registered nurse.

The Hearing Officer found administration of controlled substances along with constant monitoring of body functions to

judge insulin administration to be skilled nursing care which could not have been provided by an average adult with minimal training. Under the regulation definition of skilled services cited above, to be authorized CHAMPUS care it must be determined that the services can only be performed by a registered nurse.

Aside from the fact the sponsor performed these services in absence of a nurse, the majority of the services were not of a skilled nature. The Hearing Officer has erroneously concluded the performance of some arguably skilled services transformed all the care into skilled nursing. Due to the preponderance of nonskilled care, I reject the Hearing Officer's finding on this issue. Based on the record in this appeal, I must find the majority of the services do not qualify as skilled nursing services.

I have already determined one hour of skilled nursing services per day was required. Therefore, even if the care had not been determined to be custodial care, the majority of private duty nursing services from November 22, 1977 through June 28, 1978 were not skilled nursing services as defined under CHAMPUS regulations for purposes of CHAMPUS coverage. Therefore, I find the services of the private duty nurses from November 22, 1977 to June 28, 1978 do not meet the requirements set forth in the Department of Defense Regulation for CHAMPUS coverage, with the exception of one hour per day. Charges in excess of one hour per day are excluded from CHAMPUS coverage.

SECONDARY ISSUES

Fiscal Intermediary Misinformation and Erroneous Payment

The sponsor testified the hospital social service employee advised him she had contacted Blue Shield of Iowa and obtained verbal approval of coverage for the nursing services and that he would not have engaged the nurses unless the fiscal intermediary agreed to pay. Receipt of the payment for the services also led to his continuing the services.

While OCHAMPUS regrets misinformation by fiscal intermediaries, assuming the second-hand information is accurate, the fiscal intermediary had no authority to issue prior approval of the services. With limited exceptions not applying to this case, CHAMPUS is an "at risk" program. Claims are filed, appropriate information is obtained and the claim is adjudicated. Verbal approval is without authority and cannot bind the government.

The sponsor's argument sounds in estoppel. However, the Department of Defense and the sponsor do not know the substance of the conversation, what facts were given or the accuracy of the information given to the sponsor. Available

information is insufficient to give rise to a reliance as the conversations are not proven and the fiscal intermediary was without legal authority to give such approval. The erroneous payment likewise does not result in an estoppel as the United States is not estopped to deny erroneous payments in contravention of law or regulation. Therefore, this argument is without legal or factual merit in this appeal.

Burden of Evidence

The CHAMPUS Regulation requires complete, detailed nurses' notes for a private duty nursing claim to be considered. The appealing party claimed that the nurses' notes in this case appear to be incomplete, implying that medical care was provided that was not described in the nurse's notes. A military superior to the appealing party also asserted that the nurse in attendance did much more than act as housekeeper, attendant, sitter, or companion, and that the nurses provided skilled nursing procedures. No evidence was submitted for the Hearing File of Record to support either claim, however.

A decision on a CHAMPUS claim or appeal must be based on evidence in the Hearing File of Record. Under the CHAMPUS Regulation, the burden is on the appealing party to present whatever evidence he can to overcome the initial adverse decision. In deciding private duty nursing cases, much reliance is placed on nurses' notes because they reflect services actually provided by the nurses in attendance.

It appears that some of the nurses' notes in this case are skimpy, but this may be so because the care provided this patient was routine and repetitive. It is very probable that professional nurses would record any unusual occurence, or specific complicated procedures or services rendered. There is not sufficient evidence in this case on which to base a reversal of the decision.

SUMMARY

In summary, it is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) that, except for one hour per day of private duty nursing services provided November 22, 1977 to June 28, 1978, the services are excluded from CHAMPUS coverage because the services do not qualify as private duty nursing services under the applicable regulatory provisions and because the case primarily involves custodial care. Therefore, the claims for private duty nursing services during the period in issue and the appeal of the sponsor are denied with the exception of one hour per day of skilled nursing services for the days on which private nurses were present. This decision does not imply the services received were not necessary; it only means that care received is not a type of care for which CHAMPUS payments can be extended. While I realize the overwhelming problems associated with home

care of a seriously ill individual, I am bound to adjudicate CHAMPUS claims in accordance with statutory limitations and regulatory confines.

The matter of appropriate payment and consideration of recoupment action are referred to OCHAMPUS in accordance with this FINAL DECISION. 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