ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

14 JUL 1983

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) Case File 83-11
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 83-11 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the estate of the deceased beneficiary, as represented by her husband, a retired officer of the United States Army. The appeal involves the denial of CHAMPUS cost-sharing for inpatient private duty nursing care from February 1, 1978 through March 31, 1978 at a hospital with an intensive care unit. The amount in dispute involves approximately $14,000 in billed charges.

The hearing file of record, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS have been reviewed. Although the tape recording of the hearing includes a significant amount of static interference, the recording is sufficiently distinguishable to permit verification of the Hearing Officer's summary of the evidence.

It is the Hearing Officer's Recommended Decision that the First Level Appeal determination, issued December 18, 1980, denying CHAMPUS cost-sharing of the inpatient private duty nursing care be upheld on the basis that the CHAMPUS regulation limits coverage of such services to those performed in hospitals that do not have intensive care units. The Director, OCHAMPUS, concurs in this Recommended Decision and recommends its adoption as the FINAL DECISION, with certain modifications. In addition, the Director, OCHAMPUS, contends that the appeal involves a nonappealable issue because there was no factual dispute which if resolved in favor of the appealing party would have resulted in CHAMPUS coverage. In this case, there is no factual dispute that the hospital in which the patient was confined had an intensive care unit at the time of the inpatient private duty nursing care in issue. Therefore, the Director recommends that the FINAL DECISION dismiss the appeal as involving a nonappealable issue. 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 cost-sharing. The recommendation of the Hearing Officer to deny cost-sharing is adopted, as modified, in accordance with the recommendation of the Director, OCHAMPUS.

The FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) is, therefore, to dismiss the appeal in this case for lack of an appealable issue. In the alternative, if an appealable issue had been determined to exist, the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) would be to deny CHAMPUS cost-sharing for the beneficiary's inpatient private duty nursing care received February 1, 1978 through March 31, 1978, at Hospital and Health Center for failing to comply with regulatory criteria for CHAMPUS coverage, because it was not medically necessary, and it exceeded the appropriate level of institutional care.

FACTUAL BACKGROUND

The sixty year old beneficiary at the time of her hospitalization had metastatic carcinoma of the breast with a lytic lesion in the distal right femoral shaft and a pathological fracture in the subtrochanteric area of the right femur. The beneficiary was hospitalized at Hospital and Health Center, , California from January 31, 1978 through March 31, 1978. On February 1, 1978, she underwent surgery to the right femur. She had a postoperative wound infection and high fever. As a result of the wound infection, she underwent a second operation. Beginning with the second day of her hospitalization (at approximately 11:00 P.M.) the beneficiary had a private duty nurse in her room. She was started on a radiation treatment to the right hip and distal right femur. Despite radiation and chemotherapy, the beneficiary's metastatic disease showed signs of progression. She was discharged to her home on March 31, 1978, with private duty nursing care for continued wound care. The beneficiary is deceased and this appeal has been taken by the sponsor who is the representative of the beneficiary's estate.

CHAMPUS claims for the inpatient private duty nursing services were filed with the fiscal intermediary, Blue Shield of California, and were initially denied. The fiscal intermediary advised the beneficiary that inpatient private duty nursing services are payable only "when a hospital does not have an intensive care unit or when medical conditions (i.e., contagious disease, etc.) necessitate isolation from an existing ICU." Following a request for reconsideration, the fiscal intermediary's medical advisor authorized payment of the inpatient private duty nursing care and one hour per day of private duty nursing care in the home following hospital discharge.

Subsequently, an inquiry from the sponsor concerning the calculation of the payment was received by the fiscal intermediary. The fiscal intermediary advised the sponsor that after review of the care, it was determined that the entire amount for inpatient private duty nursing had been erroneously

cost-shared. The fiscal intermediary advised that the basis of the determination was "(w)here the institution has an ICU which is available to all patients whose medical condition requires an intensive level of skilled nursing care, no CHAMPUS benefits are available for private duty nursing, even if the ICU is full or the patient is prevented from using it because of a contagious disease." A request for recoupment was made; however, recoupment was not pursued pending the outcome of this appeal.

Initially the fiscal intermediary advised the sponsor that appeal rights were not available; however, by letter dated September 17, 1980, OCHAMPUS advised the sponsor that:

> "The lack of further appeal rights was based on the premise that there was no question of fact, i.e., the Regulation specifically excludes inpatient private duty nursing in a hospital which has an intensive care unit without any exception. This was a correct response based on the available information. However, to ensure that due process is served, we are requesting submission of additional documentation to support this appeal."

By letter dated November 3, 1980, the sponsor was further advised by OCHAMPUS that:

> "The fiscal intermediary decision upheld the initial denial and advised that there was no further appeal. This was a correct response based on the information in file. However, to ensure that due process is served, this office requested additional documentation to further review the case. The issue concerning CHAMPUS benefits for private duty nursing services in a hospital containing an ICU, is currently under review, therefore, an appeal will be accepted pending a possible policy revision."

The OCHAMPUS First Level Decision was issued December 18, 1980 and denied cost-sharing. A hearing was requested and held on March 4, 1982 in Los Angeles, California before OCHAMPUS Hearing Officer, Mr. . The sponsor and his attorney, , attended the hearing. The Hearing Officer has issued his Recommended Decision. All levels of administrative appeal have been completed and issuance of a FINAL DECISION is proper.

Issues and Findings of Fact

The primary issues in this appeal are (a) whether the appeal involves an appealable issue, and (b) whether, coverage of the inpatient private duty nursing care, received by the beneficiary while hospitalized at Hospital and Health Center,

from February 1, 1978 through March 31, 1978 is authorized under CHAMPUS.

Appealable Issue

The appeal is taken under the authority, and pursuant to procedures established by Department of Defense Regulation, DoD 6010.8-R, chapter X. At the time of appeal in this case, DoD 6010.8-R, chapter X, section A, stated that:

> "Actions under this CHAPTER X will be confined to benefit issues arising out of determinations based upon CHAMPUS Regulations and relate only to the specific dispute being considered. Actions under this CHAPTER X cannot be used to challenge such Regulations."

Effective May 1, 1983, DoD 6010.8-R, chapter X included the following definition of appealable issue.

> "Appealable Issue. 'Appealable Issue' means disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized providers regardless of the resolution of any disputed facts...."

This is not a new policy, but simply makes explicit a standard rule of appellate procedure that is and has been followed under CHAMPUS.

The Department of Defense Regulation governing CHAMPUS, DoD 6010.8-R, provides specific criteria for coverage of private duty (special) nursing. As defined by the Regulation private duty (special) nursing services means:

> "... 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 (RN) 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 providing 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).

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 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 RN, regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.
>
> (6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.
>
> ...."

The appealing party contends that denial of the claims in question fails to consider the CHAMPUS regulation provisions

which authorize coverage of medical care performed in the treatment of disease which is in keeping with the generally acceptable norm for medical practice within the United States. However, the appealing party has cited the CHAMPUS regulation provision defining appropriate medical care out of context of the provisions regarding what medical care is authorized coverage under CHAMPUS. That is, DoD 6010.8-R, chapter IV, section A.1. provides "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." (emphasis added). Thus not all medical care which is deemed appropriate is covered under CHAMPUS; rather, the medical care must be appropriate medical care and not otherwise limited or excluded from CHAMPUS coverage.

As specified in the above cited Regulation provisions regarding private duty nursing services, CHAMPUS coverage of inpatient private duty nursing services is limited to those services rendered to an inpatient in a hospital which does not have an intensive care unit. The essential fact in this case, then, is that the hospital where the beneficiary was confined, Hospital and Health Center in , California, had an intensive care unit. This fact, which is undisputed, excludes from CHAMPUS coverage the inpatient private duty nursing care received by the beneficiary, whether or not the private duty nursing services were medically necessary, appropriate medical care, or otherwise qualified skilled nursing care.

The appealing party's remaining contentions regarding the specific program limitation on inpatient private duty nursing care can be summarized as follows:

- that extenuating circumstances (e.g., if the attending physician can justify the medical necessity of the services or if the patient has a contagious disease) create an exception to the strict limitation;

- that the limitation should be interpreted as only prohibiting possible dual payments for inpatient private duty nursing care and intensive care unit costs.

The CHAMPUS regulation at DOD 6010.8-R, chapter II, B.88 defines an intensive care unit as:

> "'Intensive care unit' means a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special life saving techniques and equipment are regularly and immediately available within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the

> care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a post-operative recovery room nor a post-anesthesia room. In some large or highly specialized hospitals, the ICU's may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care or neurosurgery. For the purposes of CHAMPUS, these specialized units would be considered ICU's if they otherwise conformed to the definition of an intensive care unit."

In a published interpretation, Interpretation Number 36-78-I, issued September 14, 1978, OCHAMPUS addressed the question, "If a hospital has only a specialized ICU, such as a Burn Unit, will CHAMPUS cover private duty nursing services if the patient requires intensive care other than the kind provided by the specialized ICU?" The determination was:

> "If a hospital has only a specialized ICU (which provides burn care, for example) but no ICU level for other medical conditions, the services of a private duty (special) nurse may be considered for payment when an intensive level of skilled nursing care is medically required by the patient and the specialized ICU is not appropriate for the patient's condition."

This result flows from the definition of an ICU. A specialized ICU that is not available to all patients would not conform to the CHAMPUS definition of an intensive care unit, except for those patients who had the medical condition for which the specialized ICU was designed. The interpretation went on to provide:

> "Where the institution has an ICU which is available to <u>all</u> [emphasis in original] patients whose medical condition requires an intensive level of skilled nursing care, or has a specialized ICU which is appropriate for the particular patient's condition, no CHAMPUS benefits are available for private duty (special) nursing. Private duty nursing is not covered in a hospital with a general ICU, or specialized ICU which meets the patient's needs, even if the ICU is full or the patient is prevented from using it because of a contagious disease. Where the hospital generally provides an ICU level of care, the hospital is expected to furnish that level of care to all patients whose medical condition requires such care."

The Hearing Officer found that the appealing party failed to produce sufficient or persuasive evidence that exceptions exist to the specific Regulation limitation for coverage of inpatient private duty nursing care. I agree with this finding.

I can readily understand the appealing party's concern about the denial of claims for inpatient private duty nursing care ordered by the attending physician. However, the Regulation provision which became effective June 1, 1977, was adopted after substantial policy review.

When health insurance first arrived on the American scene, hospitals did not have intensive care units (either general or special), nor post operative recovery rooms, nor intermediate care facilities, nor much of the other technical support we take for granted today. Hospital accommodations consisted of large wards, semi-private rooms and private rooms. Critical patients, i.e., those requiring very intensive professional skilled nursing services, were usually placed in a private room with a special duty Registered Nurse. To the extent possible, the private duty nurse performed those kinds of services that are today performed in an intensive care unit. Health insurance and medical benefits programs (like CHAMPUS) eventually made coverage of this type of private duty nursing care available (although it was by no means universally included in all programs).

As intensive care units became the standard for the majority of hospitals, the character of inpatient private duty nursing began to change. The nurses performing this duty were often other than registered nurses. And because the private duty nurses no longer handled the patient requiring the intensive, professional skilled nursing care (these critical patients were being placed in the ICU), the care they rendered either duplicated what should reasonably be expected to be provided by the hospital nursing or other professional and support staff, or simply provided comfort and convenience services. It became increasingly clear to those who managed medical care funds that private benefit dollars were being inappropriately spent for private duty nursing care that did not represent essential and necessary medical care -- rather it was duplicative or primarily comfort and convenience.

In 1976, when CHAMPUS regulation DoD 6010.8-R was being developed the policy concerning private duty nursing was reviewed. The question under consideration at that time was whether benefits should be extended for private duty nursing under <u>any</u> circumstances. It was concluded that except for emergency type cases that might be admitted to a hospital without an ICU, that CHAMPUS benefit dollars were not being appropriately used for private duty nursing services rendered in a hospital. Further, it was and is the position of DoD that charges for daily hospital room and board are intended to include adequate nursing and other support care at whatever the level the patient requires. Patients have a right to expect necessary care from a hospital, at a level adequate for the particular condition and circumstance. If the hospital cannot provide the required care, elective admissions should be postponed and emergency patients

referred to another hospital or transferred as soon as possible. It is totally unacceptable for a hospital to keep a patient if they do not have adequate staff or facilities to handle the needs of that patient.

CHAMPUS is not the only program to face up to this issue. Several years ago both the large Government-wide plans for civilian Federal employees (i.e. Blues and Aetna) eliminated benefits for all inpatient private duty nursing, whether or not the hospital has an ICU and regardless of the circumstances. Because Medicare came along later the problem was recognized at the time legislation was passed and Congress wisely excluded special duty nursing under that program from its onset. Medicare rulings interpreting this exclusion have denied Medicare coverage of private duty nursing when the hospital did not have an ICU, when the patient was transferred from an ICU to make space available, and when a patient required isolation, which an ICU could not provide.

A Social Security Administration official provided the following explanation to the General Accounting Office for its policy of excluding private duty care: If Medicare paid for private-duty nursing, physicians might find it difficult to resist pressures, from the patients and their families and from hospital and nursing administrators anxious to reduce their nursing workload, to authorize private-duty nursing care in cases where it was not medically necessary.

As previously stated, the essential undisputed fact in this case is that the beneficiary received inpatient private duty nursing care while confined in a hospital with an intensive care unit. While the record indicates that the ICU was not available to the beneficiary due to a postoperative wound, no exception to the CHAMPUS ICU limitation exists. The patient's postoperative wound is analogous to the situation where a contagious disease prevents admission to an ICU; under such circumstances the hospital is still expected to furnish the level of care needed by all patients.

In view of the specific CHAMPUS regulation limitation of coverage of inpatient private duty nursing care and the undisputed fact that Hospital and Health Center had an ICU at the time of the beneficiary's hospitalization, denial of the beneficiary's claims in this case is not appealable. No disputed question of fact exists which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS cost-sharing of the beneficiary's claims. The CHAMPUS regulation provision limiting CHAMPUS coverage is clear and unambiguous and the administrative appeal procedure may not be used to challenge the Regulation. The only issue which may be disputed in such a case is whether or not the hospital had an ICU. I find that there is no dispute regarding the existence of an ICU in this case and, therefore, the appeal is dismissed as involving a nonappealable issue. The fiscal intermediary decision and the OCHAMPUS decision to deny CHAMPUS coverage of the beneficiary's inpatient private duty nursing care from

February 1, 1978 through March 31, 1978, is the FINAL DECISION in this case.

Private Duty Nursing

Although I have determined that this appeal involves a nonappealable issue, due to the time and effort expended by the appealing party, I will address the primary issue regarding whether the beneficiary's inpatient private duty nursing care would have qualified for CHAMPUS coverage in the absence of the Regulation's specific ICU limitation.

As previously stated, DoD 6010.8-R, chapter IV, A.1., authorizes CHAMPUS cost-sharing for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, subject to all applicable limitations and exclusions. Specifically excluded under chapter IV, G., are services which are

> "1. Not Medically Necessary....
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> *
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> 3. Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.
>
> *
> *
> *"

DoD 6010.8-R, chapter II, B-104, defines "medically necessary" as:

> "... the level of services and supplies (that is, frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury...."

The Regulation provision specifically addressing coverage of private duty nursing care has been cited earlier in this DECISION. The essential provision contained in DoD 6010.8-R, chapter IV, C.3.o., is, 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."

The record indicates that the sixty year old patient was admitted to the hospital on January 31, 1978, with metastatic carcinoma of the breast with a lytic lesion in the distal right femoral shaft and a pathological fracture in the subtrochanteric area of the right femur. The patient was hospitalized for two months during which she underwent surgery to the right femur and had a post-operative wound infection with spiking fevers.

Subsequent to surgery on February 1, 1978 the nurses' notes include the statement, "would like to have private nurse." The surgeon's report for the February 1, 1978 surgery notes that, "the patient tolerated the procedure well, and left the OR in satisfactory condition." A similar comment was made following the February 17, 1978 surgery for the incision and debridement of the wound infection. The doctor's orders for February 1, 1978, state, "arrange for private nurses according to pt. desire." Commencing February 1, 1978, then inpatient private duty nursing was provided the patient until her discharge on March 31, 1978. The record also includes a statement from the orthopedic surgeon, dated February 22, 1978, that the beneficiary was in need of private duty nursing; however, the statement makes no mention of a need for the level of care furnished by an intensive care unit.

The hospital records show isolation was ordered by the treating physician on February 13, 1978. And, in a statement dated August 7, 1978, the physician stated, "This is to verify that a private room was necessary ... she had to be placed in isolation due to an open wound (draining), and therefore could not be admitted to the intensive care unit."

The report of the consulting physician, upon examining the patient on March 21, 1978, states that the patient is "well-developed, well nourished ... female in no distress." His recommendation included, "if she becomes and remains afebrile as she appears to be doing, I think we should send her home with a nurse for her dressing changes."

Finally, the appealing party's representative contends the inpatient private duty nursing care should be cost-shared by CHAMPUS not only because the ICU was not available to the patient, but because the regular hospital staff was not qualified or capable of rendering the kind of care required by the beneficiary and that a private duty nurse was necessary for the specialized care and needs related to the critical condition of the beneficiary. In support of these contentions, a letter from the Associate Director, Nursing Services for Hospital and Health Center was submitted to the Hearing Officer after the Hearing. The letter states that:

> "During the period from January 31, to March 31, 1978, while a patient at

> Hospital and Health Center, [the beneficiary] was in need of one to one nursing care. It would have been inappropriate for her to be admitted to ICU because of an open, draining, suppurating wound caused by a metastatic bone lesion fracture of the femur that had become infected. Intravenous drip antibiotics and steroids were constantly being administered and monitored and frequent wound dressings were required.
>
> [The beneficiary] also suffered from intractable asthma which necessitated constant machine monitoring and frequent intravenous and pulmonary medication at this time. She also suffered from breast to bone to liver to spleen to brain cancer and was under massive radiation and chemotherapy during this period of hospitalization.
>
> [The beneficiary] was also subject to allergic reactions to medication and was being monitored and treated medically for these conditions at this same time. She was being fed and medicated intravenously under machine monitoring. In addition, she was extremely apprehensive, being unable to move because of the leg hip fracture, intravenous catheters and pulmonary attachments. She was in need of full-time care, which the regular hospital staff could not provide on a one to one basis; therefore, her physicians were asked to write orders for private duty nurses. Regular staff nurses could not provide special duty nursing care to a patient with accuity needs as high as [the beneficiary's]. Private duty nurses were ordered by her physicians, Doctor , Doctor , and Doctor ."

The record does not support all of the statements made by the Associate Director of Nursing regarding the need for one-to-one nursing care. First, she states that ICU admission would have been inappropriate due to the open, draining suppurating wound that had become infected. However, in that patient isolation was not ordered until February 13, 1978, this was not a factor in the ordering of private duty nursing commencing February 1, 1978.

The Associate Director of Nursing also stated that the private duty nurses were necessary because the patient "was being fed and medicated intravenously." However, the daily nurses' notes contradict this as the notes detail the meals (breakfast, lunch and dinner) taken by the patient. In addition, the nurses' notes reference the hospital staff "I.V. nurse" coming in to check or adjust the I.V.

The Associate Director of Nursing also stated that the patient "was in need of full-time care, which the regular hospital staff could not provide on a one-to-one basis; therefore, her physicians were asked to write orders for private duty nurses." This statement is in conflict with the nurses' notes and doctor's orders for February 1, 1978 that state the patient wanted private duty nurses. At best, the statement of the Associate Director for Nursing is an admission that the hospital staff could not provide necessary care.

OCHAMPUS obtained from the Colorado Foundation for Medical Care a medical review of the inpatient private duty nursing care. The initial review on behalf of the Colorado Foundation for Medical Care was conducted by two medical doctors, one a specialist in orthopedic surgery and the other in internal medicine. It was their opinion that the record did not show that the intensive care unit was the appropriate level to treat the beneficiary's condition. The medical reviewers concluded the beneficiary was a very sick person who because of a very slow healing and infected hip wound needed to be isolated from other patients. It was their opinion a private room was appropriate for isolation and infection control techniques from February 13, 1978 until discharge. Prior to February 13, 1978, it appears the patient was treated appropriately on the ward. The medical opinion of the reviewers was that all of the services performed by the private duty nurses could have been performed by the hospital's nursing staff. They did note that care for the patient would have placed substantial demands on the hospital's nursing staff. They further opined that the need for isolation was not so much to prevent further infection but to prevent the infection from being passed to other patients. As made clear in a follow-on review by one of the doctors, they were not recommending a standard of care between the usual level of care received and that offered by private duty nursing. The medical recommendation by the reviewers was for the usual level of care received in a hospital for infection control techniques.

It is the Hearing Officer's recommended findings that the nursing care furnished by the private duty nurses was skilled nursing care which could only be provided with the technical proficiency and scientific skills of a R.N.; that the nursing care was medically necessary in the treatment of the beneficiary; and that the nursing care was not available from the hospital's regular nursing staff, not by reason of the skill or proficiency required, but by reason of the non-availability of the regular nursing staff. While I agree with the first two findings, I reject the third finding as unsupported by the record.

The statement of the Associate Director for Nursing, submitted after the Hearing, is the strongest evidence in support of the Hearing Officer's finding that the necessary care was not available from the hospital staff. Consideration given to this after the fact statement, which is inconsistent on several points with the record, is less than the consideration given to records created contemporaneously with the care in question. The nurses' notes and the doctor's orders indicate the private duty nurses

were arranged at the request of the patient. The consulting physician's report on March 21, 1978 and the surgeon's reports following the two surgeries make no reference to a need for one-to-one nursing or a need for inpatient private duty nursing. In addition, the medical reviewers opined that, while the patient would have placed an increased demand on the hospital's nursing staff because of the infection control techniques, this type of care is usually handled by a hospital nursing staff.

Based on the record, I find that the inpatient private duty nursing care was not medically necessary, but should have been provided by the hospital nursing staff. The lack of sufficient hospital staff necessary to furnish the usual inpatient nursing care expected in an acute hospitalization does not justify inpatient private duty nurses. I find that use of inpatient private duty nurses in this case was above the appropriate level required to provide necessary medical care and is excluded from CHAMPUS coverage under DoD 6010.8-R, chapter IV, G. and the provisions on private duty nursing care cited above.

Secondary Issues

Medical Necessity of Admission to an Intensive Care Unit

The appealing party's representative contends that had the patient been admitted to the ICU, CHAMPUS would have cost-shared the more expensive ICU costs. That contention assumes that the ICU care would have been determined to be medically necessary. In this case, the record would not support the medical necessity of placement in an ICU.

It is clear the beneficiary was a very sick patient, suffering from a terminal illness. And, there is no dispute that after February 13, 1978, the beneficiary required isolation from other patients. It was the opinion of the medical reviewers, however, that the beneficiary did not require treatment in an ICU; rather, the patient required a hospital's usual level of care for infection control techniques.

There is no statement in the record by any physician that treated or saw the patient ordering ICU level of care. The treating physician did say an ICU was not available to her, because of her wound infection; he did not state she needed that level of care. Similarly, the Associate Director for Nursing states that admission to an ICU would have been inappropriate due to her wound infection, but she did not state the patient required ICU level of care.

Finally, the record does not indicate that the patient's private room had any equipment or was subject to procedures normally associated with an ICU. This is an additional indication that the patient did not require an ICU level of care.

Erroneous Payment

Although the fiscal intermediary initially denied the claims for inpatient private duty nursing care, subsequent review in response to a congressional inquiry resulted in payment of some of the claims by the fiscal intermediary. Based on the above determinations that the care was not authorized under CHAMPUS, the fiscal intermediary payments were erroneous.

The amount in dispute is estimated to approximate $14,000. Because the fiscal intermediary's copies of the claims were not included in the hearing record, it is difficult to determine the actual amount in dispute. While the amount in dispute is not significant to questions regarding CHAMPUS coverage of the inpatient private duty nursing services, the actual dollar figure must be determined in any action to recover the erroneous payments. This matter is referred to the Director, OCHAMPUS for appropriate recoupment action under the Federal Claims Collection Act.

SUMMARY

In summary it is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) that the inpatient private duty nursing services received by the appealing party from February 1, 1978 through March 31, 1978, do not qualify for CHAMPUS coverage as private duty nursing under the applicable regulatory authorities, were not medically necessary, and were above the appropriate level of institutional care. Therefore, the claims for inpatient private duty nursing on the dates indicated, and the appeal of the beneficiary's estate are denied. Further, the CHAMPUS regulation specifically limits coverage of inpatient private duty nursing care to services received by a patient confined in a hospital without an intensive care unit. In view of the undisputed fact that the appealing party received the inpatient private duty nursing while confined in a hospital with an intensive care unit, this case lacked an appealable issue required by the CHAMPUS administrative appeal procedures and the appeal is also dismissed on that basis. The case is returned to the Director, OCHAMPUS for appropriate action under the Federal Claims Collection Act to finalize the recoupment of erroneous payment of the claims in this case. Issuance of this FINAL DECISION completes the administration 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