ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

23 SEP 1983

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	OASD(HA) File 83-27
Sponsor:	)	FINAL DECISION
	)	
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPVA appeal OASD(HA) Case File 83-27 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the participating provider.

The recipient of medical services for which the provider is appealing is a beneficiary of the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), as the widow of a 100% disabled veteran. CHAMPVA is administered under the same or similar limitations applicable to the medical care furnished certain beneficiaries under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). By agreement between the Administrator, Veterans Administration, and the Secretary of Defense, pursuant to the provisions of Title 38 United States Code, Section 613, CHAMPVA claims are processed and appealed under rules and procedures established by the CHAMPUS regulation, DoD 6010.8-R.

This appeal involves a question of CHAMPVA coverage of psychiatric services provided, at a rate of four one-hour sessions per week, to the beneficiary from June 1, 1977, until August 9, 1979. The total charge for the psychiatric services incurred by the beneficiary for these dates was approximately $9,700.00. The CHAMPUS/CHAMPVA Fiscal Intermediary cost-shared only two one-hour sessions per week of psychiatric care received from June 1, 1977, through April 1978. Coverage of the remaining claims was denied because the beneficiary and provider failed to adequately document the medical/psychiatric necessity of the psychiatric treatment in excess of the general CHAMPUS/CHAMPVA limitation of two sessions per week and sixty sessions in total. Although a claim for services received during June 1978 was paid, the fiscal intermediary furnished notice that the claim had been paid in error.

The hearing file of record, the tape of oral testimony 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 the OCHAMPUS First Level Appeal decision denying CHAMPVA coverage in excess of two 1-hour sessions per week or more than 60 outpatient sessions in total be upheld. The Recommended Decision is based on the finding that there is insufficient documentation to support the medical necessity of the sessions in excess of two sessions per week or for more than 60 sessions in total.

The Director, OCHAMPUS, concurs with the Recommended Decision as far as the decision goes; however, the Director believes the Recommended Decision is incomplete. All sessions of care in the episode of care involved psychoanalysis, and the Hearing Officer specifically found that the provider failed to furnish adequate documentation to determine whether or not he is qualified to provide psychoanalytic treatment. Based on this finding, the Director, OCHAMPUS, recommends issuance of a FINAL DECISION which denies CHAMPVA coverage of the entire episode of care and all claims for psychoanalysis.

Under DoD 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, concurs in the recommendation of the Director, OCHAMPUS, to deny CHAMPVA payment for psychoanalytic services provided the beneficiary from June 1, 1977, until August 9, 1979. To the extent the Hearing Officer's Recommended Decision is inconsistent with this determination, it is rejected.

The FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPVA coverage of the entire episode of care and all claims for psychoanalysis. The decision to deny coverage of the care in question is based on findings that such care was not documented to be medically/ psychologically necessary and the provider's qualifications to provide psychoanalytic treatment have not been established.

FACTUAL BACKGROUND

The beneficiary is eligible for benefits under the provisions of the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) as the widow of a 100% disabled veteran. At the hearing, the attending physician testified that the beneficiary began a course of outpatient psychotherapy in May 1974 and participated in psychoanalytic therapy sessions at the rate of four sessions per week from May 1974, uninterrupted until August 9, 1979. The record contains CHAMPVA claims filed by the

participating provider on a monthly basis commencing with care provided on June 1, 1977.

The appealing party testified at the hearing that claims for care furnished between May 30, 1974, and June 1, 1977, were initially filed with, and paid by, Blue Cross-Blue Shield of Greater New York, the CHAMPUS/CHAMPVA Fiscal Intermediary during that period. The hearing record contains no other information regarding CHAMPVA claims for services prior to June 1, 1977.

It should be noted that prior to June 1, 1977, CHAMPUS and CHAMPVA were regulated by joint services regulation, primarily referenced as Army Regulation 40-121. On January 10, 1977, the new regulation (DoD 6010.8-R) was promulgated and was implemented effective June 1, 1977. The Regulation sets forth specific limits and review periods for psychiatric benefits under CHAMPUS/CHAMPVA. Consequently, the subsequent fiscal intermediary for the State of New York, at that time Blue Cross of Rhode Island, applied the specific limits and paid all claims from June 1977 through April 1978 but allowed only two treatments per 7-day period. The claim for services in May 1978 was denied. The fiscal intermediary subsequently paid the claim for services provided in June 1978; however, the fiscal intermediary advised that this was paid in error. All subsequent claims were denied through August 1979, at which time the therapy was terminated. All claims were submitted by the treating physician on a participating basis and were submitted without supporting documentation.

The treating physician apparently first questioned the denial of benefits in December 1978. As a result of his inquiries, an informal review decision was issued by the fiscal intermediary on April 27, 1979, which upheld the previous denials on the basis that the information submitted by the provider was insufficient to make a benefit determination. The treating physician was requested by the fiscal intermediary to provide specific information in order to have the denial of cost-sharing reviewed at the reconsideration level. It should be noted that on May 6, 1979, the treating physician furnished a hand-written summary of the treatment he provided to the beneficiary; however, no medical records were provided as requested. The fiscal intermediary referred the case with all available documentation to the American Psychiatric Association for medical review. The medical review report issued on December 27, 1979, confirmed the previous determinations that the information submitted was insufficient to make a determination of the medical/psychological necessity or appropriateness of the treatment provided. Therefore, the fiscal intermediary, on January 15, 1980, upheld the previous denials and offered further appeal to OCHAMPUS.

The treating physician responded to this denial by the fiscal intermediary on January 26, 1980, by providing a more lengthy hand-written summary of the beneficiary's history, diagnosis, and treatment. However, the treating psychiatrist once again failed to provide the actual records upon which the summary was based. The fiscal intermediary forwarded this information to OCHAMPUS on

February 18, 1980, requesting OCHAMPUS review. In an effort to obtain more complete medical records, OCHAMPUS attempted to obtain a specific authorization for release of the medical records from the beneficiary even though her signature on the claim form specifically authorized the release of medical records to the fiscal intermediary and OCHAMPUS. The beneficiary refused to sign the authorization for release. OCHAMPUS, therefore, referred the case to the American Psychiatric Association for medical review on the basis of the record as submitted without the requested, additional medical documentation.

The medical reviewer again confirmed the inadequacy of the medical records and information provided and questioned the propriety of the level of care and the duration of treatment. Based on the two medical reviews received from the American Psychiatric Association and the documentation as provided by the treating physician, the OCHAMPUS First Level Appeal Determination upheld the previous denials because the documentation provided was insufficient to establish the medical/psychological necessity of more than two psychotherapy sessions per week or more than 60 outpatient visits.

The treating physician requested a hearing, and a hearing was held by , Hearing Officer, on July 29, 1981. Present at the hearing were the treating physician and his counsel. The Hearing Officer has submitted her Recommended Decision and all prior levels of administrative review have been exhausted. Issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether sufficient documentation was provided to determine if the psychoanalytic sessions provided the beneficiary were medically/psychologically necessary and appropriate medical care for coverage under CHAMPVA.

Medical Necessity/Appropriate Medical Care

The patient in this case is a CHAMPVA beneficiary as the widow of a 100% disabled veteran. Pursuant to title 38, United States Code, section 613, CHAMPVA beneficiaries are entitled to medical care subject to the same or similar limitations as medical benefits furnished to certain CHAMPUS beneficiaries. By agreement between the Administrator, Veterans Administration, and the Secretary of Defense, CHAMPVA claims are processed and appealed under rules and procedures established by CHAMPUS regulation, DoD 6010.8-R.

The CHAMPUS regulation, DoD 6010.8-R, chapter IV, A.1., defines the scope of benefits 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 . . . ."

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

The regulation defines "medically necessary" in 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 the concept of appropriate medical care."

"Appropriate medical care" is defined in 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 accepted norm for medical practice in the United States.
>
> "b. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training or education as licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
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> "c. The medical environment in which the medical services are performed is at the level adequate to provide the required medical care."

As specifically concerns coverage of psychiatric procedures, DoD 6010.8-R, chapter IV, C.3.1., provides as follows:

> "(1) Maximum Therapy Per Twenty-Four-Hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than one hour of individual and/or group psychotherapy in a twenty-four hour period, inpatient or outpatient. However, for the purposes of crisis intervention only, CHAMPUS

benefits may be extended for up to two hours of individual psychotherapy during a twenty-four hour period.

"(2) Psychotherapy: Inpatient.

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"(3) Review and Evaluation: Outpatient. All outpatient psychotherapy (group or individual) are (sic) subject to review and evaluation at eight session (visit) intervals. Such review and evaluation is automatic in every case at the initial eight session (visit) interval and at the twenty-four session (visit) interval (assuming benefits are approved up to twenty-four sessions). More frequent review and evaluation may be required if indicated by the case. In any case where outpatient psychotherapy continues to be payable up to sixty outpatient psychotherapy sessions, it must be referred to peer review before any additional benefits are payable. In addition, outpatient psychotherapy is generally limited to a maximum of two sessions per week. Before benefits can be extended for more than two psychotherapy sessions per week, peer review is required."

The mandating review and evaluation of psychotherapy claims imposes a requirement for information greater than that provided by the standard claim form. To ensure the availability of necessary information, DoD 6010.8-R, chapter VII, B.4., proclaims, as a condition precedent to the provision of medical coverage, the right of OCHAMPUS and its fiscal intermediaries to request and receive medical records and other related documents that pertain to a CHAMPUS or CHAMPVA claim.

Therefore, the responsibility for perfecting a CHAMPVA claim rests with the beneficiary or participating provider. Before a CHAMPVA claim will be adjudicated, the claimant must furnish, upon request, that information which may reasonably be expected to be in his or her possession and which is reasonably necessary to make a benefit determination. In fact, the patient's signature on the claim form specifically authorizes the release of medical records and information to the fiscal intermediary and OCHAMPUS. Failure to furnish the requested information may result in denial of the claim.

The claims for therapy received from June 1, 1977, through April 1978 were processed by the fiscal intermediary under the psychiatric procedures guidelines. That is, only two sessions per week were cost-shared, up to 60 sessions in total. Prior to the hearing, requests for additional information were made on several occasions by the fiscal intermediary and OCHAMPUS in order to determine the necessity and appropriateness of care beyond the limits established by the Regulation. The limited information furnished in response to the requests was inadequate to determine the medical/psychological necessity of the care.

At the hearing the treating physician testified that his treatment of the beneficiary was medically necessary and at the appropriate level of care. He stated that the beneficiary's sleep disorder and depression were treated by psychoanalysis not psychotherapy because of the beneficiary's extreme intelligence, her station in life as an important research scientist, her alcoholism, and her suicidal and murderous rages which placed the beneficiary's job in jeopardy. The treating physician further testified that the psychoanalysis was his treatment of choice for the beneficiary, and it was his opinion that this was the most beneficial treatment for the beneficiary.

The treating physician stated that the psychoanalysis commenced in May 1974, consisted of three phases (initial, middle, and terminal), and that this treatment had been working very well for the beneficiary. It was his opinion that there was no medical indication to change her course of treatment in 1977 because the beneficiary was in the middle stage of analysis and stoppage at that point would have been dangerous. The treating physician further indicated that he consulted with another psychoanalyst for overview periodically throughout the course of treatment and that it was the opinion of this individual that the treatment was proper. The treating physician testified that supportive treatment of psychotherapy and medications for the sleep disorder and depression would not have been beneficial because the patient had suicidal and murderous rages and was an alcoholic which would make the use of medications dangerous.

The treating physician testified that the beneficiary began the terminal stage of her psychoanalysis in October 1978 and that her treatment ended on August 9, 1979. He testified that psychoanalysis is properly conducted on a regular basis of four or five sessions a week and that a 5-year period of analysis is well within the acceptable treatment time limits.

In addition to the testimony provided by the treating physician, he also consented to the admission of his case notes into the record.

Due to the nature of the case notes, it was decided to once again refer the case to the American Psychiatric Association for medical review. The medical review opinion of the American Psychiatric Association reviewer was provided to the Hearing Officer on November 17, 1982. That medical reviewer stated that

he could not adequately address the issue of whether or not the psychoanalysis conducted by the treating psychiatrist was necessary because the office notes were illegible. One of the main concerns of the medical review physician was the fact that the treating psychiatrist had not followed the procedures outlined in the American Psychiatric Association's Peer Review Manual for describing the reasons and criteria under which a treating physician would prescribe psychoanalysis for the patient. It was the opinion of the reviewing physician that the treating physician needed to address the issue of why other briefer and less expensive psychotherapy treatments would not have been preferable to psychoanalysis.

Although stating that the information provided to him was not adequate to properly respond, the reviewing physician did attempt to provide a medical review. In response to the question of whether psychoanalysis was "an appropriate" method of treatment, the reviewing physician stated:

> ". . . I believe psychoanalysis was an appropriate treatment modality for this patient. In order to understand this answer in context, it must be understood that OCHAMPUS does not require practitioners of medicine to offer a single exclusive option for the treatment of almost any medical diagnosis. The number of treatments available in the field of medicine that are truly specific are narrowly limited, e.g., to vaccination for smallpox, and certain hormonal replacement therapies. Even, for example, in the treatment of appendicitis, there is evidence to indicate that the use of antibiotics may be as effective as the use of surgery. And certainly, in a stress-related illness, such as peptic ulcer, the government is quite willing to pay for medical or surgical treatment. Therefore, the meaning of the word 'appropriate' should not be misunderstood to mean 'Is it the only?' or even 'Is it the cheapest form of treatment?'
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> "The best evidence that psychoanalysis is an appropriate form of treatment can be offered by filling out the outline required in the Peer Review Manual for Psychoanalysis. As I indicated above, this outline requires the psychoanalytic provider to describe why other, briefer, less expensive forms of treatment (in terms of energy, time, and emotional pain for the patient as well as money) might not have been preferable.

> "However, for this patient, it may be noted that, since the evidence for biological depression (loss of appetite with weight loss, constipation, loss of energy, early morning awakening with difficulty facing the day, and loss of sexual interest with ability to perform when actually aroused) were not described by [the provider], it may be assumed that they were not present. If so, then the indications for the use of antidepressant medication are not nearly as strong as the indications for the use of psychotherapy. Under the rubic of the various psychotherapies, psychanalysis may indeed have been the treatment of choice, because of the severity of the patient's difficulty, i.e., that supportive psychotherapy may not have been as effective as the mixture of confrontation and support characteristic of psychoanalysis."

The reviewing physician did find support for the diagnosis of depression; however, he found no support in the record for the diagnosis of insomnia. Also the reviewing physician opined that ". . . if psychoanalysis is an 'appropriate form of treatment for this patient, it would be entirely proper for four sessions a week to be the appropriate level throughout the entire course of the therapy.'" The reviewing physician also concurred with the prior American Psychiatric Association Medical Review that if psychoanalysis was appropriate then more than 60 sessions were necessary.

Finally, the reviewing physician indicated that the treating physician had not demonstrated through his affiliations, education, or treatment of the patient that he was indeed a qualified psychoanalyst. The claim forms were signed by the provider with the title physician/psychoanalyst. At the hearing the treating physician testified that he had been privately trained by a New York Psychoanalytic Institute training analyst. Further, throughout the course of treatment of the beneficiary, the provider had consulted with a senior colleague many times. However, the medical reviewer provided the following comments:

> "What are [his] qualifications as a psychoanalyst? . . . [He] said 'I received my psychoanalytic training from Dr. , a New York psychoanalytic Institute training analyst, done privately.' This does not qualify [him] as a psychoanalyst in any ordinary usage of the word . . . . He does not list among his affiliations any local or national psychoanalytic organization that recognizes his psychoanalytic 'training.'

> "However . . . organizational affiliation of an individual claiming to be a psychoanalyst, or even the specific credentials of his training should not be a primary issue. The basic question should be whether or not the individual can 'think psychoanalytically.' This is the reason it is so important for [him] to use the format of the Psychoanalytic Peer Review Manual which would demonstrate to any other psychoanalyst whether or not [he] knows how to think psychoanalytically.
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> "It does not increase the provider's credibility to point out . . . that he consulted with a senior colleague a dozen times, who helped him bring material 'to the fore and to work it through' after [he] had tried to stop the psychoanalysis in January 1979 . . . . I regard this as evidence of [his] serious and laudable intention to carry out the treatment in the best possible manner, given his basic lack of what is ordinarily thought of as psychoanalytic training. However, I will adhere to the recommendation that if he is able to think psychoanalytically as demonstrated by his response to the requirements of the peer review manual, then that is what is important for a peer reviewer to know."

On November 18, 1982, the OCHAMPUS Hearing Officer, by letter, offered the treating physician the opportunity to conform with the suggestion of the reviewing physician to submit further evidence in accordance with the guidelines contained in the American Psychiatric Association's Peer Review Manual's section on psychoanalytic peer review. Even though afforded the opportunity to respond to the comments of the medical reviewer and provide additional documentation, the treating physician elected not to provide the information, and the record was closed by the Hearing Officer.

The Hearing Officer found that the appealing party has failed to meet his burden to furnish adequate information and documentation to support the medical/psychological necessity of the psychoanalytic therapy in excess of the general limitations (i.e., two sessions per week and 60 sessions in total) established by regulation. A review of the record, the testimony presented at the hearing, and the medical review opinion issued by members of the American Psychiatric Association leads me to concur with the Hearing Officer's findings. However, not only do I find insufficient evidence to support the medical necessity of therapy in excess of two sessions per week and 60 sessions in total, I find insufficient evidence to support a finding of

medical necessity for any of the psychoanalytic therapy. This finding does not imply that therapy was not required by the patient, only that the provider has failed to document adequately the case, his choice of treatment, the treatment plan, and the case summary. In the absence of adequate documentation to support the medical/psychological necessity of therapy, CHAMPVA coverage cannot be authorized.

I further find that the psychoanalytic therapy was not appropriate medical care because the record does not adequately document the provider's qualifications to perform the claimed services. As noted earlier, medical necessity includes the concept of appropriate medical care; and appropriate medical care is defined, in part, in DoD 6010.8-R, chapter II, B.14., as:

> "b. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training or education and is licensed and/or certified by the state where the service is rendered or appropriate national organization and otherwise meets CHAMPUS standards . . ."

The final reviewing physician specifically noted that the treating physician testified at the hearing that he had received his psychoanalytic training from a training analyst at the New York Psychoanalytic Institute. In the opinion of the reviewing physician this did not qualify the treating psychiatrist as a psychoanalyst in ". . . any ordinary usage of the word." It was noted that the treating physician did not list among his affiliations any local or national psychoanalytic organization that recognized his psychoanalytic training. Further, the reviewing physician pointed out that the provider's credibility was not enhanced when he revealed at the hearing that he consulted with a senior colleague several times and that this consultant helped the treating psychiatrist bring material ". . . to the fore and to work it through . . ." As stated by the reviewing physician: "I regard this as evidence of [the treating physician's] serious and laudable intention to carry out the treatment in the best possible manner, given his basic lack of what is ordinarily thought of as psychoanalytic training."

I concur with the finding of the Hearing Officer and the opinion of the reviewing physician that the treating psychiatrist failed to supply adequate documentation to enable OCHAMPUS and the Hearing Officer to determine whether or not he is qualified to provide psychoanalytic treatment. Therefore, in the absence of evidence the provider was qualified to perform psychoanalytic therapy, none of the therapy can be considered appropriate medical care and must be denied CHAMPVA coverage.

SECONDARY ISSUE

Recoupment

In view of the findings that none of the psychoanalytic therapy can be cost-shared under CHAMPVA, the issue of the provider's billing procedure is moot and requires no finding. However, the Director, OCHAMPUS, is directed to review the record in this case and initiate appropriate action under the Federal Claims Collection Act to recover all erroneous payments of claims.

SUMMARY

In summary it is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) that the psychoanalytic sessions provided the beneficiary from May 30, 1974, to August 9, 1979, be denied because the care has not been documented to show that it was medically/psychologically necessary or appropriate medical care. Therefore, the claims for the psychoanalytic therapy for this period and the appeal are denied. Because CHAMPVA funds have been expended for these services, it is necessary to initiate action to recover the erroneously paid funds. Therefore, the case is returned to the Director, OCHAMPUS, for appropriate action in accordance with the Federal Claims Collection Act. 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. F. Beary, III, M.D.
Acting Assistant Secretary