ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

HEALTH AFFAIRS

DEC 9 1983

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	OASD(HA) Case File 83-10
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 83-10 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the minor beneficiary, represented by his father.

The appeal involves the question of CHAMPUS coverage of inpatient psychiatric care provided the 18-year-old son of an active duty officer in the United States Army from January 8, 1980, to May 19, 1980. The total psychotherapy charges incurred by the beneficiary were $5,934.00.

The Hearing File of Record, the tape of oral testimony and argument presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed.

It is the Hearing Officer's recommendation to uphold the OCHAMPUS appeal decision that crisis intervention had not been documented in the file, resulting in denial of CHAMPUS coverage of psychotherapy sessions in excess of established limits on the number and duration of psychotherapy sessions. In addition, the Hearing Officer performed his own calculation of possible CHAMPUS payments of the claimed psychotherapy sessions and recommended CHAMPUS recovery of $3,212.00 as erroneous overpayments in this case. The Director, OCHAMPUS, concurs in the Hearing Officer's Recommended Decision and recommends its adoption as the FINAL DECISION to the extent it finds that crisis intervention is not supported by the hearing record, resulting in denial of CHAMPUS coverage of individual psychotherapy sessions in excess of established limits. The Director, OCHAMPUS, however, disagrees with the Hearing Officer's calculation of services recommended for coverage under CHAMPUS and recommends rejection of that portion of the Hearing Officer's Recommended Decision.

Under Department of Defense Regulation 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 Principal Deputy Assistant Secretary of Defense (Health Affairs), acting as the authorized designee of the Assistant Secretary, after due consideration of the appeal record adopts the recommendation of the Hearing Officer to deny CHAMPUS cost-sharing of the psychotherapy sessions exceeding established limits on the number and duration of such sessions; however, the Hearing Officer's findings and recommendation regarding the psychotherapy sessions to be cost-shared under the CHAMPUS limits are rejected as not supported by regulation and established guidelines.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, that the CHAMPUS claims for inpatient psychotherapy sessions provided by a psychiatrist and a clinical psychologist from January 8, 1980, through May 19, 1980, cannot be cost-shared as billed because the hearing record does not establish the existence of crisis intervention; in the absence of crisis intervention, CHAMPUS will cost-share only those inpatient psychotherapy sessions in this case which do not exceed one session of up to 1 hour in any 24-hour period and five sessions of up to 1 hour each in any 7-day period. In addition, it is the finding in this case that the clinical psychologist was the admitting and attending provider and, therefore, the CHAMPUS regulation provision on concurrent inpatient care restricts CHAMPUS coverage of the individual psychotherapy sessions furnished by the clinical psychologist; the claims for individual psychotherapy sessions furnished by the psychiatrist are denied CHAMPUS coverage by the FINAL DECISION. Finally, I find that the hearing record does not adequately document the existence or duration of the individual psychotherapy sessions as claimed; therefore, only 52 ½-hour sessions of individual psychotherapy by the clinical psychologist may be cost-shared under this FINAL DECISION.

FACTUAL BACKGROUND

The 18-year-old beneficiary was admitted to Community Hospital on January 7, 1980, after an unsuccessful suicide attempt. The attending physician, , M.D., provided the following information by letter dated May 26, 1981:

> "He was found hanging by his neck following ingestion of an apparent overdose of Isoclor. He was initially combative and disoriented. He was treated with endotracheal intubation, gastric lavage and intravenous fluids and monitoring in the Intensive Care Unit. Over

> the subsequent 8 hours, patient became alert, oriented and seemingly [rational].
>
> "It was concluded that the patient was acutely psychotic and acutely suicidal and necessitated inpatient psychiatric management. Consultation was placed with Institute concerning admission. When he was medically stable he was transferred via ambulance to Institute on January 8, 1980."

The beneficiary was confined in Institute from January 8, 1980, until discharged on May 19, 1980. The discharge summary indicates an admitting diagnosis of "passive aggressive personality disorder" and a final (discharge) diagnosis of "intermittent explosive disorder" and "infectious mononucleosis."

The discharge summary also contains the following information regarding the patient's history and activities which culminated in his hospitalization. Until age 12, the beneficiary was a happy and well-behaved child. He was motivated and a good student through fifth grade, at which time his behavior reversed. He then began displaying passive aggressive behavior and became very manipulative after the sixth grade, the beneficiary engaged in aggressive, hostile acting-out behavior including the use of drugs (including alcohol), reckless driving, and disobedience of parents.

The patient was seen by a clinical psychologist, , Ph.D., in July 1978 for evaluation. Dr. indicated in a letter dated June 16, 1981, that the beneficiary had significant emotional problems for which he needed treatment.

> "The evaluation indicated a very labile youngster capable of significant acting out behavior. While suicidal ideation was not an acute concern, the data did indicate that self destruction behavior was part of his overall pattern. This included the use of drugs . . . . He would alternate between cycles of feeling depressed and guilty to periods of restlessness, rumination and being unable to sit still."

The record indicates that the beneficiary's suicide attempt on January 7, 1980, was triggered by his loss of driving privileges and use of the family car following the wrecking of his car. After being stabilized at Community Hospital, he was reported as alert, coherent, rational, and cooperative upon admission to Institute on January 8, 1980. The patient was reported as guarded in his response and behavior upon admission, and his physical examination and laboratory test results were within normal limits through hospitalization.

While at Ridgeview Institute, the beneficiary was under the care of a psychiatrist, Lawson Bowling, M.D., and a clinical psychologist, John Currie, Ph.D. On May 19, 1980, the beneficiary was discharged from Ridgeview Institute for transfer to Deveroux School in Pennsylvania.

CHAMPUS claims for psychotherapy services during the patient's confinement at Ridgeview Institute were submitted by the sponsor to the then CHAMPUS Fiscal Intermediary, Mutual of Omaha Insurance Company. The claims included the following services of Dr. Bowling:

Dates of Service	Charges
January 9, 24; March 20, 26, 28, 31; April 2, 4, 9, 11, 14, 21, 23, 25, 28, 30; May 18, 19	One hour individual therapy and hospital visits at $60 = $1,080
January 18, 22, 25; February 5, 11, 28; March 4, 7, 10	One-half hour individual therapy and hospital visits at $30 = $270
January 30; February 12, 21; March 6; April 1	One hour family therapy at $60 = $300
February 27	One-half hour family therapy at $30 = $30

The claims also included the following services of John Stuart Currie, Ph.D., psychologist:

Dates of Service	Charges
January 8 to March 8, 1980	61 days of daily hospital care and individual psychotherapy at $30 per day based on a 7-day week = $1,830
January 15, 1980	Psychological evaluation and testing = $240
March 10 to May 19, 1980	52 days of daily hospital care and individual psychotherapy at $42 per day based on a 5-day week = $2,184

A CHAMPUS cost-share of $1,535.60 was paid by the fiscal intermediary on the claims for Dr. Bowling's services. The total charge of $1,680.00 was reduced by the fiscal intermediary by $144.40 for charges exceeding allowable charges.

A CHAMPUS cost-share of $3,020.00 was paid by the fiscal intermediary on the claims for Dr. Currie's services. The total charge of $4,254.00 was reduced by the fiscal intermediary by $1,234.00 for services exceeding the CHAMPUS limit on frequency

of individual psychotherapy sessions and for charges ($20.00) exceeding the allowable charge for psychological testing.

The beneficiary's appeal of the denied charges resulted in the fiscal intermediary's decision that the claims had been properly processed. The beneficiary then appealed to OCHAMPUS.

OCHAMPUS referred the case for medical review under the CHAMPUS American Psychiatric Association Peer Review Project. The reviewer is a Diplomate in Psychiatry and a Diplomate in Child Psychiatry. After reviewing the limited file, the reviewer opined that the records lacked documentation to support a finding of severity, complexity, or crisis persisting after the patient's admission. He also opined that the diagnosis listed on the claim forms, DSM II 308.4 (Unsocialized Adjustment Reaction of Adolescence), was not substantiated. In addition, he opined that no documentation existed regarding the need for more than 1 hour of individual psychotherapy on any day nor more than 5 hours of therapy in any week. Finally, the reviewer opined that the record does not make clear the clinical indications for a psychiatrist and a psychologist seeing the patient on the same day.

Review of the case by OCHAMPUS resulted in the following action: First, OCHAMPUS determined that the claim for family therapy by Dr. had been improperly cost-shared by the fiscal intermediary. The CHAMPUS limit on coverage of family therapy is one session per month with a maximum of four sessions per year. The claim for Dr. services included three family sessions during February 1980, and the fiscal intermediary should have denied coverage of the February 21, 1980, session ($60.00) and the February 27, 1980, session ($30.00).

OCHAMPUS also determined that the fiscal intermediary erroneously cost-shared psychotherapy sessions by Dr. and Dr. when in combination the beneficiary received psychotherapy in excess of 1 hour session per 24-hour period and five sessions in any 7-day period. By assigning attending physician status to Dr. , OCHAMPUS determined that Dr. charges be reduced by $570.00 for ½-hour sessions on days psychotherapy was also provided by Dr. . In addition, Dr. charges were reduced by $524.00 for psychotherapy services found to exceed the five sessions per 7-day period limit.

Finally, OCHAMPUS determined that the fiscal intermediary had erroneously paid the psychotherapy charges at rates in excess of the then existing reasonable charge levels. The erroneous payments were determined as $102.00 for Dr. charges and $610.00 for Dr. charges. OCHAMPUS directed the fiscal intermediary to recover all erroneous payments, including the payment for services exceeding CHAMPUS psychotherapy limits and the payment of charges in excess of the reasonable charge levels.

The beneficiary appealed the OCHAMPUS determination and requested a hearing. The beneficiary contends that all psychotherapy sessions should have been cost-shared by CHAMPUS because the crisis intervention exception to the CHAMPUS limit on psychotherapy coverage is applicable to his case.

The hearing was held by , CHAMPUS Hearing Officer, on September 21, 1982. The Hearing Officer has submitted his Recommended Decision, and all prior levels of administrative review have been exhausted. Issuance of a FINAL DECISION is therefore proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this case are 1) whether crisis intervention was required in this case permitting CHAMPUS coverage of psychotherapy in excess of the general coverage limitations, and 2) whether the beneficiary's condition required concurrent inpatient care by a psychiatrist and a clinical psychologist.

Inpatient Psychotherapy - Crisis Intervention

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a health benefits program authorized under law as set forth in chapter 55, title 10, United States Code. The Department of Defense Appropriation Act of 1979, Public Law 95-457, in appropriating funds for CHAMPUS prohibited the use of such funds for ". . . any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician, dentist, [or] clinical psychologist . . ." This prohibition has consistently appeared in each subsequent Department of Defense Appropriation Act.

Department of Defense Regulation DoD 6010.8-R was issued under authority of statute to establish policy and procedures for the administration of CHAMPUS. The Regulation describes CHAMPUS benefits in DoD 6010.8-R, chapter IV, A.1., 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, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional providers as well as

professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment.

"Individual Professional Providers.

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"2. Covered Services of Physicians and Other Authorized Individual Professional Providers.

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"i. Psychiatric Procedures.

"(1) Maximum Therapy Per Twenty-Four (24)-hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than one (1) hour of individual and/or group psychotherapy in any twenty-four (24)-hour period, inpatient or outpatient. However, for the purpose of crisis intervention only, CHAMPUS benefits may be extended for up to two (2) hours of individual psychotherapy during a twenty-four (24)-hour period.

"(2) Psychotherapy: Inpatient. In addition, if individual or group psychotherapy, or a combination of both, is being rendered to an inpatient on an ongoing basis (i.e., non-crisis intervention), benefits are limited to no more than five (5) one-hour therapy sessions (in any combination of group and individual therapy sessions) in any seven (7) day period."

In view of the specific limitations on CHAMPUS coverage of psychotherapy in the absence of crisis intervention, the burden rests with the appealing party to document his contention that crisis intervention was required in this case. Prior to the hearing, the appealing party's representative substantially amended the then existing record by submitting such records as the hospital progress notes, statements by providers of care, and a January 15, 1980, psychological evaluation.

A letter dated July 8, 1981, with signature blocks for Dr. and Dr. (but signed only by Dr.) set forth the basis for their opinion that crisis intervention was required. Included in this itemization were: the patient's history of aggressive, hostile acting-out behavior; his suicide attempt immediately preceding his admission to Institute which demonstrated his aggressive, hostile, explosive outbursts of threatening, angry behaviors requiring specific interventions outside himself; and specific medical orders by Dr. responding to the patient's crisis. The specific medical orders cited were: January 24, 1980, restricted to cottage behavioral control room (BCR), suicide precaution; February 15, 1980, BCR for out-of-control behaviors, cottage restriction, Thorazine for agitation; February 18, 1980, Thorazine PRN for agitation; February 22, 1980, no visitors or telephone calls, cottage restriction, Thorazine for agitation; April 13, 1980, staff escort; and, April 29, 1980, BCR for severe agitation and aggressive behavior, cottage restriction.

The amended record was referred to the psychiatrist with the CHAMPUS American Psychiatric Association Peer Review Project for another review. Again the reviewer opined that the record does not support an existence of an on-going crisis during the patient's confinement. In his professional judgement, "crisis intervention emphasizes the identification of a specific event precipitating an emotional trauma and is characterized [by] an abrupt or decisive change in the person." In addressing the July 8, 1981, letter from Dr. and Dr. , the reviewer opined that the letter described "dramatic behaviors but [did] not address the crucial feature of a crisis; namely, the temporal component being acute."

By letter dated September 17, 1982, Dr. took issue with the CHAMPUS reviewer's opinion. In that letter, Dr. cited the description of crisis found in the CHAMPUS Peer Review Manual for psychologists. That definition is:

> "A crisis almost always involves an abrupt and substantial change in behavior, which is usually associated with a clear precipitating situation, and is in the direction of severe impairment of functioning or marked increase in personal distress."

In Dr. opinion, the totality of the beneficiary's behavior, both before and during confinement at Ridgeview Institute, demonstrates the crisis situation.

The Hearing Officer concluded that the evidence did not support a finding that the patient was in crisis or that the psychotherapy was directed toward such a crisis. While the evidence indicates that a crisis occurred (i.e., the attempted suicide on January 7, 1980), the evidence of record does not indicate the crisis period persisted. According to the discharge summary, the patient, upon

admission to Institute on January 8, 1980, was "alert, coherent, calm, rational, and cooperative." The report also notes:

> "Claims a total amnesia for alleged overdose and hanging episode. Guarded in responses and behaviors. Not overtly depressed; no thought disorder. Judgement and reasoning superficially and overtly not impaired but total history demands total assessment . . . ."

The Hearing Officer also noted the CHAMPUS reviewer's observations that the "mental status examinations" portion of the same report contains nothing to suggest the patient was in crisis upon admission.

Finally, the Hearing Officer concluded that the July 8, 1981, letter from Dr. and Dr. citing medical orders believed to indicate crisis, merely indicated the presence of some manifestations of the patient's illness indicating the appropriateness of hospitalization. The Hearing Officer did not believe the manifestation established the requirement for an inordinate amount of individual therapy.

I agree with the Hearing Officer. A thorough review of the medical records indicates that this beneficiary required hospitalization for the evaluation and treatment of a diagnosed mental disorder, and that such hospitalization was both the appropriate level of care and reflective of a standard of medical care in the United States. What is not justified is the crisis intervention level of services within the hospital. While the beneficiary did require the intensity and comprehensiveness of services provided in a standard psychiatric hospital setting, his medical and psychological circumstances were such that more comprehensive-intensive services ("crisis intervention" or "psychiatric intensive care") were not required. While all psychiatric hospitalizations represent a crisis for which intervention is required, it would be expected that psychiatric units would offer the basic structure and protections that would be sufficient for evaluation and treatment for all but the most severely psychologically decompensated or dangerous persons.

It is generally accepted that a crisis is an acute, short-term situation, i.e., a turning point for good or bad in a patient's condition. As described by the CHAMPUS reviewer, "an acute exacerbation of some previous disorder." The record in this case does not support finding the existence of a crisis during the patient's confinement which would require extraordinary psychotherapeutic intervention to correct or prevent the continuation of crisis. In fact, despite assertions that an ongoing crisis existed during the entire period of confinement which required intensified therapy, the patient was given a 24-hour pass almost weekly, commencing on February 2, 1980, to be with his family.

In view of the above, I find that crisis intervention was not required during the patient's confinement in Institute from January 8, 1980, to May 19, 1980.

Inpatient Psychotherapy - Maximum CHAMPUS Coverage

As quoted above, the CHAMPUS regulation, in the absence of documented crisis intervention, establishes maximum limits on CHAMPUS coverage of psychotherapy. CHAMPUS benefits are limited to no more than 1 hour of individual and/or group psychotherapy in any 24-hour period, and no more than five therapy sessions in any 7-day period. Having found that crisis intervention was not adequately documented in the case, a determination must be made regarding the maximum psychotherapy sessions CHAMPUS can cost-share.

As noted by the Hearing Officer, the appealing party raised the issue of proper interpretation of the CHAMPUS regulation limitation. It is the appealing party's argument that the regulation limit on psychotherapy in any 7-day period pertains to the number of "hours" rather than "sessions." That is, CHAMPUS should apply the limit to cover up to 5 hours of psychotherapy in any 7-day period, rather than five sessions in any 7-day period.

The Hearing Officer correctly rejected this argument. It is the intent of the CHAMPUS regulation that coverage of psychotherapy be limited to one session, not to exceed 1 hour, in any 24-hour period and five sessions, not to exceed 1 hour per session, in any 7-day period.

In view of the duplication of psychotherapy by Dr. and Dr. on many dates in this case, it is necessary to determine the primary provider of care in order to determine whose services should be covered by CHAMPUS.

The CHAMPUS regulation, DoD 6010.8-R, in chapter II, defines attending physicians as follows:

> "Attending Physician. 'Attending Physician' means the physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, an assistant-at-surgery or an anesthesiologist is not an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time."

As noted by the Hearing Officer, a medical doctor normally assumes the role of attending physician in a hospital confinement, and services of other providers would be considered

CHAMPUS policy on conjoint therapy at the time of care in issue was established by OCHAMPUS regulation interpretation number 22-77-I, dated December 1, 1977. Although conjoint therapy was not subject to the limitations established for inpatient psychotherapy sessions, CHAMPUS coverage was limited by the interpretation as follows:

> "Limitations on Conjoint Therapy. CHAMPUS therapy visits are limited to no more than one (1) per month and/or four (4) in any 12-month period."

In view of the above, the Hearing Officer found that OCHAMPUS correctly determined that Dr. family therapy sessions exceeded the CHAMPUS guidelines for coverage. The three sessions in February 1980 exceeded the one session per month limit and the sessions on February 21 and 27, 1980, cannot be cost-shared by CHAMPUS. I agree and adopt the Hearing Officer's finding as the finding of the Assistant Secretary of Defense (Health Affairs).

Inpatient Medical Care - Concurrent

The CHAMPUS regulation, DoD 6010.8-R, in chapter IV, C.3.f., specifically limits CHAMPUS coverage of concurrent medical care as follows:

> "Inpatient Medical Care: Concurrent. If during the same admission a beneficiary receives inpatient medical care (non-emergency, non-maternity) from more than one physician, additional benefits may be provided for such concurrent care if required because of the severity and complexity of the beneficiary's condition. Any claim for concurrent medical care must be reviewed before extending benefits in order to ascertain the medical condition of the beneficiary at the time the concurrent medical care was rendered. In the absence of such determination, benefits are payable only for inpatient medical care rendered by the attending physician."

The Hearing Officer appropriately has raised the issue of CHAMPUS coverage of concurrent inpatient medical care. In addition, the Hearing Officer correctly cited as authority on the issue of concurrent inpatient care by a psychiatrist and a clinical psychologist the previously issued CHAMPUS FINAL DECISION, OASD(HA) Case File 16-79.

The facts of that particular case are not dissimilar in that the beneficiary received psychotherapy from both a psychiatrist and a psychologist during an inpatient confinement of approximately 5 months. On the issue of whether or not the services of two practitioners were required, the following opinion was issued:

"Severity of Patient's Mental Illness. First it was claimed by the appealing party that the patient's mental illness was so serious and severe that it justified two primary practitioners rendering concurrent individual psychotherapy to the patient. The clinical information submitted in this case was minimal. The patient did appear to have significant symptomatology prior to her initial hospital confinement. She had agreed to outpatient psychotherapy with the appealing party which apparently intensified some of her symptoms, particularly suicidal and homicidal ideation, and it was determined hospital confinement was required. There was no evidence presented of aggressive or self destructive acts prior to confinement, however. Symptoms presented on admission to the hospital were related as anxiety, depression, aggitation [sic], anorexia and insomnia. While the Hearing File of Record suggests the existence of a significant mental disorder for which hospital confinement was no doubt appropriate, because complete clinical records were not provided, it was not possible to support a finding that the patient's condition was of such severity and complexity that she required, in addition to the hospital confinements and the attending psychiatrists, concurrent in-hospital individual psychotherapy by more than one primary practitioner. The regulation speaks to the issue of concurrent in-hospital medical care provided by more than one physician. While in this case the appealing party is a clinical psychologist rather than a physician, the intent of the regulation is clear and it would not be reasonable to apply less restrictive standards to the services of a clinical psychologist than to a physician. In the absence of clinical evidence indicating that the patient's condition was so severe and complex as to require concurrent individual psychotherapy, a negative finding must be assumed. (Reference: CHAMPUS Regulation DoD 6010.8-R, chapter IV, section C, paragraph 3.f.)

"Concurrent Inpatient Medical Care (i.e., Concurrent Individual Psychotherapy). Throughout the Hearing File of Record as well as in oral testimony the appealing party continued to maintain that the concurrent inpatient care by two practitioners was justified. The appealing party further

> claimed he was the primary practitioner rendering individual psychotherapy--that the two psychiatrists in the case were, in fact, rendering medical services not psychotherapeutic services. However, this is contradicted in that the Hearing File of Record contains claim forms which have been certified to by the attending psychiatrists, billing for psychotherapy rendered during the same time period as [the other provider]. While it is true that one of the psychiatrists also provided chemotherapy, no evidence was presented which would indicate the psychiatrists in the case did not render the psychotherapy for which they billed. Because the first psychiatrist rendered only thirty minute therapy sessions (as opposed to the one hour permitted by the Program during a twenty-four hour period), an effort was made to justify extending benefits for the other thirty minutes of unused therapy time to the appealing party. However, because the lack of clinical records precluded a finding that the patient's condition was sufficiently severe to permit concurrent essentially independent therapy from two primary practitioners, such an approach could not be considered. Benefits cannot be extended for services in excess of Program limits, regardless of the alleged exception [sic] circumstances, if it cannot be conclusively determined that the exceptional circumstances actually existed. (References: CHAMPUS Regulation DoD 6010.8-R, chapter IV, subsection A.5 and subsection 3.f)"

It was the Hearing Officer's opinion that the circumstances in this case do not satisfy the above indicated requirements. I agree. As in OASD(HA) Case File 16-79, the current appealing party's problems were of the type for which hospital confinement was appropriate, but it has not been established that the required care was beyond the controlled environment of a hospital, its staff, and a single attending physician (provider).

The Hearing Officer also concluded that the record does not support "the presence of complex, serious, and multiple, but unrelated, medical conditions." As noted by the Hearing Officer, inherent differences between psychiatrists and psychologists exist in education and treatment approaches; however, the primary focus of the CHAMPUS regulation is not the practitioner's treatment, but the patient's condition.

The reviewer from the CHAMPUS American Psychiatric Association Peer Review Project, stated that:

> "The record does not make clear the clinical indications for having a psychiatrist and a psychologist see the patient on the same day; a most unusual practice."

In rebuttal, Dr and Dr. state that, although a staff clinical psychologist admitted the patient for hospitalization, the hospital by-laws, rules, and regulations require appointment of a staff psychiatrist as attending psychiatrist. "From there, the patient's treatment is a conjoint team procedure."

Regardless of the hospital by-laws, rules, and regulations, CHAMPUS will not cost-share claims which do not meet the Regulation criteria. Therefore, in addition to denying claims for services by the two psychotherapists for any therapy sessions in excess of the CHAMPUS limits, the Regulation provisions restrict CHAMPUS coverage only to care furnished by the attending physician (provider). Having previously held that Dr. was the attending provider, the claims for inpatient psychotherapy services by Dr. are denied, and any CHAMPUS payments to Dr have been erroneous.

It is recognized that Dr. may have been singly responsible for prescribing and monitoring the patient's medication. That is, the staff clinical psychologist may not be authorized to order medication. In such a case, appropriate claims for such services and hospital visits may be authorized under the concurrent inpatient care provision.

Dr. services were billed on the basis of "individual psychotherapy and hospital visits." Under the concurrent inpatient care provision, Dr. charge must be denied; the portion of the charge related to the hospital visits may be cost-shared by CHAMPUS only at the reasonable charge for a hospital visit and only for those dates when the visits are documented in the medical records.

Perfecting a CHAMPUS Claim

The CHAMPUS regulation, DoD 6010.8-R, in chapter VII, A., places the burden of perfecting a claim on the CHAMPUS claimant, as follows:

> "A. General. The Director, OCHAMPUS (or a designee), is responsible for assuring that benefits under the CHAMPUS Program are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted which provides sufficient information as to . . . medical services and supplies provided . . . in order to permit proper, accurate and timely adjudication of the claim . . . .

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"3. Responsibility for Perfecting Claim. It is the responsibility of the CHAMPUS beneficiary (or sponsor) and/or authorized provider . . . to perfect a claim for submission to the CHAMPUS contractor . . . ."

Having determined that no crisis intervention existed in this case, that concurrent inpatient care was not appropriate, and that Dr. was the "attending physician," it remains to be determined what claims for Dr. services may be cost-shared by CHAMPUS. After a thorough review of the appeal record, two matters remain to be resolved regarding the perfection of the claims. First, what was the duration of Dr. psychotherapy sessions; second, what claims are documented in the medical records as having been performed?

As the Hearing Officer observed, the fiscal intermediary had difficulty in establishing whether Dr. psychotherapy sessions were 1 hour or ½ hour. Dr. two bills indicate:

- "Individual psychotherapy and hospital visits 61 days @ $30.00 each."

- "Individual psychotherapy and hospital visits 52 days @ $42.00 each day."

It should be noted that the 61-day claim is based on 7 days of care per week, and the 52-day claim is based on 5 days of care per week.

In response to a fiscal intermediary request for itemization on March 27, 1980, Dr. advised that the care was ½ hour individual therapy and hospital management daily. In response to a July 9, 1980, inquiry, Dr. stated that 1 hour of therapy was provided. The latter response was supplemented with the following explanations on July 17, 1980:

"The following is an explanation of 'Daily Hospital Services'

"The type of therapy involved in Daily Hospital Services is always on an individual type basis. Length of time involved on a daily basis for total inpatient care differs from day to day. Daily Physician Services involves, in addition to daily individual psychotherapy, 24-hour a day 'ON CALL' status of the doctor, staff consultations regularly with clinical assistants, nurses

> and others on the hospital staff, also regular consultation with the attending physician (M.D.), telephone consultations with family, friends and employers regarding patient and/or helping to give some insight regarding patient's illness, and any and all emergencies which should arise during the course of hospitalization.
>
> "Taking into consideration the above criteria, estimated length of time invclved on a daily basis - - - one hour. Charge for Daily Hospital Services is on a daily rate of $30.00 for each date listed on the attached claim."

The CHAMPUS reviewer opined that Dr. method of billing is not the usual or customary method. The reviewer's comments were:

> "The letter from , Ph.D., dated July 17, 1980, makes clear no attempt was made at determining actual professional time spent treating this young man; but rather, an arbitrary figure of sixty minutes has been assigned daily and routinely.
>
> "It is not usual or is it customary to make a charge for 'twenty-four-hour-a-day on-call status of the doctor.' It is both usual and customary for physicians to be on such a status for all of their patients both in the office and in the hospital 365 days a year. The actual time spent with the patient . . . is what physicians customarily charge for."

In reviewing the record on appeal, OCHAMPUS applied the reasonable charge of $28.00 for ½-hour psychotherapy sessions to Dr. services; OCHAMPUS, therefore, concluded that Dr. psychotherapy sessions could only be considered to be ½ hour sessions. This conclusion appears reasonable in view of the fact Dr. billed charges ($30.00 and $42.00) more clearly approximate the reasonable cost for a ½-hour session than the $60.00 reasonable charge for a 1-hour psychotherapy session.

The Hearing Officer concluded that the record supported the decision to classify Dr. services only as ½-hour psychotherapy sessions. I agree. The burden of establishing the existence and duration of services claimed under CHAMPUS is on the claimant or appealing party. In this case, the record is inadequate to establish that the psychotherapy services exceeded ½ hour.

Of equal importance in determining what charges of Dr. are to be cost-shared by CHAMPUS in this case, however, is the existence of limited documentation of services. On this issue, the CHAMPUS reviewer stated:

> "I do want to draw your attention, additionally, that though Dr. billed for sixty-one days of individual psychotherapy from January 8 through March 8, there are only notes in the chart for twenty-five dates! Additionally, in his second bill for fifty-two days of service, there are notes only for twenty-seven days."

It is further noted that, during the period Dr. was billing for services 7 days per week (January 8 through March 8, 1980), the patient was absent from the hospital on 3 1-day passes for visits with his parents.

It is usual and customary for therapists to record notes of their sessions with patients. In the absence of such notes or other appropriate documentation, it is difficult to determine that services were actually performed or that the services were appropriate and medically necessary in the treatment of the patient.

CHAMPUS will cost-share only those medically necessary services which are appropriately and adequately documented. Subject to the previously discussed limits for CHAMPUS coverage of psychotherapy sessions, therefore, the CHAMPUS claims for Dr. services can only be considered for the 52 documented sessions out of the 113 sessions billed.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the CHAMPUS claims for inpatient psychotherapy services provided by a psychiatrist, , M.D., and a clinical psychologist, Ph.D., from January 8, 1980, through May 19, 1980, cannot be cost-shared as billed. The hearing record does not establish the existence of crisis intervention and, therefore, CHAMPUS coverage of the psychotherapy sessions is limited by Regulation to one session of up to 1 hour in any 24-hour period and five sessions of up to 1 hour each in any 7-day period. In addition, CHAMPUS coverage of the claims for family/conjoint therapy is specifically limited by CHAMPUS policy to one session per month with a maximum of four sessions per year. The hearing record supports a determination that Dr. was the admitting and attending provider; therefore, the CHAMPUS regulation provision on concurrent inpatient medical care restricts CHAMPUS coverage of individual psychotherapy sessions only to Dr. services and requires denial of individual psychotherapy care furnished by Dr. Bowling. Only those services of Dr. which are documented as essential medical management, uniquely limited to qualified,

medical physicians (e.g., prescription and monitoring of medication) may be considered for CHAMPUS cost-sharing. Finally, the hearing record does not adequately establish the existence or duration of the services claimed for CHAMPUS cost-sharing; only 52 ½-hour sessions of individual psychotherapy by Dr. are authorized for CHAMPUS coverage.

This FINAL DECISION in no way implies that the patient in this case did not require inpatient psychotherapeutic care. It only finds that because of the absence of clinical information and adequate documentation, neither the existence of a crisis nor the severity and complexity of the patient's condition can be established or confirmed. Therefore, additional CHAMPUS coverage of psychotherapy cannot be authorized over and above those furnished by the clinical psychologist as limited by established guidelines on the number and duration of authorized psychotherapy sessions.

Except as specifically authorized by this FINAL DECISION, all CHAMPUS claims for services performed by Dr. and Dr. are denied, and the beneficiary's appeal is denied. The Director, OCHAMPUS, is directed to review the beneficiary's claims file and to take action as appropriate under the Federal Claims Collection Act to recover any erroneous payments issued in this case. The Director, OCHAMPUS, after reviewing this case record, also should take appropriate action to review providers who fail to appropriately and adequately document care for which CHAMPUS claims are submitted.

Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

Vernon McKenzie
Acting Principal Deputy Assistant Secretary