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	)	
	)	
Sponsor:	)	OASD(HA) Case File 83-34
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) file 83-34 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party in this case is the wife of a retired officer in the United States Army, as represented by her husband.

The appeal involves the question of CHAMPUS coverage of inpatient care provided the beneficiary from July 21, 1979, to August 1, 1979. The total hospital charge incurred by the beneficiary for these dates was $1,632.80. The CHAMPUS Fiscal Intermediary allowed the claim for diagnostic charges in the amount of $531.80, but denied coverage of the hospitalization charge ($1,012.00) and meal ticket charge ($89.00) because the hospitalization was not medically necessary and was above the appropriate level of care. Of the $531.80 charge allowed, the fiscal intermediary paid $398.85 as the 75% CHAMPUS cost-share. However, the beneficiary's supplemental insurance paid $408.20 as the patient's 25% cost-share of the total hospital charge. The amount in dispute, then, is the $825.75 unreimbursed claim for the hospital room and board.

The hearing file of record, the tapes and oral testimony presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. The amount in dispute, therefore, is $825.75. It is the Hearing Officer's recommendation that CHAMPUS coverage for inpatient care from July 21, 1979, to August 1, 1979, be denied because it was not medically necessary and was above the appropriate level of care. The Director, OCHAMPUS, concurs in the Recommended Decision and recommends its adoption as the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs).

The Acting Principal Deputy Assistant Secretary of Defense (Health Affairs), acting as the authorized designee for the Assistant Secretary, after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer to deny CHAMPUS payment for inpatient room and board received from

July 21, 1979, to August 1, 1979, and hereby adopts the recommendation of the Hearing Officer as the FINAL DECISION. The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS coverage of inpatient room, board, and meal tickets from July 21, 1979, to August 1, 1979, and to approve CHAMPUS coverage, on an outpatient basis, of the diagnostic tests conducted for the beneficiary at the hospital. The decision to deny inpatient coverage from July 21, 1979, to August 1, 1979, is based on findings that such care was not medically necessary and was above the appropriate level of care.

FACTUAL BACKGROUND

The beneficiary, who was 50 years old at the time of this admittance, had been treated by the admitting physician for several years. The known medical problems of this beneficiary prior to admission, as described by her physician, were: intervertebral disc disease; spondylolisthesis (cervical and lumbosacral spine) which accounts for the beneficiary's neck, left shoulder, and back problems; bronchial asthma; perennial rhinitis, chronic sinusitis with no surgical identifiable problem (i.e., clear sinus x-rays); increased body weight; and a history of hypertension controlled by therapy.

The July 19, 1979, Interval Notes indicate recent development in the beneficiary's case immediately preceding admission as follows:

> "The interval course has been one of the usual frequency of bronchitis episode (four in six months) controlled with antibiotics. Recent new problems has [sic] been as follows: she has been aware of a lump within her chest (crowding breathing). This is not related to asthma or bronchitis. This is not precipitated by exertion. Also she has had three episodes of true vertigo since May (of an acute character). The first episode was associated with leg weakness of a marked type for a short interval. It is not clear whether the two manifestations were related or occurred coincidently [sic] together. The patient notes that the cervical pillow has helped considerably in terms of neck and back pain. Physical examination revealed a well developed white lady in no acute distress."

The physicians recommended that the patient continue her present program and that the patient be scheduled for admission to , University Medical Center for further testing. The beneficiary obtained a nonavailability statement from , and was admitted to University Medical Center on July 21, 1979.

The physical examination at time of admission revealed a somewhat heavy but well-developed individual in no acute distress. The vital signs were: blood pressure 140/80; pulse 88; respiration 16; weight 183; height 5 feet 4 inches. The head and neck area revealed a right tympanic membrane retracted with no acute inflammation, normal ocular motion of pupillary reflexes, horizontal nystagmus induced by lateral motion, no rotary or vertical nystagmus; swollen nasal mucous membranes, adequate nasal passages in the nose, mouth, and pharynx; normal membranes in mouth and pharynx; decreased transillumination of maxillary sinuses; and supple neck. The thorax was symmetrical with adequate excursions. Cardiovascular examination indicated regular rhythm with no significant murmurs. The neurological examination showed no weakness of the lower extremities. The doctor's notes further indicate that this beneficiary was on interval therapy which included Motrin and Tylenol for treatment of pain; occasional Lufyllin at bedtime; Hydrochlorothiazide for treatment of hypertension; intermittent courses of antibiotics; and occasional use of nasal saline irrigations for nasal congestion and occasional use of Metaproterenol or Primatene bronchodilator inhaler.

Upon admission to the of the University Medical Center, the nursing notes indicate that the patient stated she was being admitted to determine the cause of her nausea, dizziness, headaches, and ear problem. These notes indicate that the beneficiary was in no apparent distress at the time of admission and seemed to be alert and cooperative. The nursing notes also reflect the scheduling of such tests or examinations as ENT, EKG, cardiology consultation, skull x-rays, and blood study. With one exception (i.e., while the beneficiary was taking a scheduled lab test she vomited and was unable to complete the test), the course of hospitalization was uneventful. While hospitalized, the beneficiary did not experience any distress or acute discomfort and indicated on several occasions that she had had a comfortable day with no complaints.

The discharge summary contains the following information:

> "The patient was seen in neurologic consultation. Assessment was of vertigo secondary to a disturbance of the vestibular system. The recommendation was not to investigate the problem further at this time and to provide symptomatic treatment. An audiogram revealed normal hearing in the right ear and borderline normal findings in the left ear. Orthopedic consultation (Dr. McCollum) was consistent with a thoracic outlet syndrome. Shoulder shrugging exercises were recommended in order to strengthen upper trapegius [sic] muscles. The recommendation was further made that in

absence of improvement thoracic surgical management would be appropriate. Cardiologic assessment (Dr.) was of a history of hypertension and of no evidence for pain of cardiac origin.

"Ear, nose and throat consultation (Dr.) was of no primary otologic disorder and the inference was drawn that the vertigo might be related to the cervical spine disease. Chronic rhinosinusitis was also noted. The patient was seen by the dietition and detailed instructions were given in a low fat diet. Electronystagmogram was within normal limits. An exercise ECG test was stopped because of substernal sharp pain and was uninterpretable due to resting ST segment changes. The resting ECG revealed a normal sinus rhythm and nonspecific ST segment abnormalities. It was unchanged in comparison to a tracing of 12/21/78. Mastoid x-rays revealed good pneumatization with no change in basic landmarks. The internal auditory canals were well visualized and failed to show any significant abnormalities. Sinus x-rays revealed mild membrane thickening and some loss of laminal detail in the left maxillary region which would be the result of previous infection. The right ethmoids were cloudy. The sphenoid sinuses show no obvious abnormalities. The nasopharyngeal soft tissues were within normal limits and the skull base revealed normal anatomic detail. Chest x-ray revealed unremarkable parenchyma and a normal heart size with a density in the right cardiophrenic angle that was unchanged from 1975 and presumably reflected no active process. A fasting lipid profile revealed elevation of triglycerides. Routine blood chemistries (18) were entirely normal. The hemoglobin, red blood cell indices, white blood cell count and differential white blood cell count were unremarkable as were the serology and urinalysis. Treatment included physical therapy (shoulder exercises), Theodur, bronchial hygiene measures, dietary therapy and Motrin. Some improvement ensued.

"The diagnoses upon discharge included the following:

1) thoracic outlet syndrome and cervical spine disease
2) bronchial asthma
3) perennial rhinitis-chronic sinusitis
4) increased body weight
5) hypertension-essential
6) spondylolisthesis
7) intervertebral disc disease"

On discharge, the physician recommended the following for the beneficiary: activity/shrug exercises for the thoracic outlet syndrome; a 1,200 calorie lowfat diet; prescriptions for Valium, Theodur, Motrin, HydroDiuril, Benadryl, Marax, Metaproterenol inhaler. The final diagnoses were thoracic outlet syndrome, bronchial asthma, perennial rhinitis-chronic sinusitis, increased body weight, hypertension-essential, spondylolisthesis, and intervertebral disc disease.

The beneficiary submitted a claim on September 4, 1979, for the services provided in the amount of $1,632.80, less the supplemental insurance payment of $408.20. On October 23, 1979, the then CHAMPUS Fiscal Intermediary, Blue Cross of Southwest , informed the beneficiary that the $1,012.00 charge for room and board for this 11-day hospitalization was denied as not being medically necessary. The $89.00 charge for the meal tickets was denied on the same basis. The fiscal intermediary allowed $263.50 for the blood tests, urinalysis, the ophylline serum, exercise tolerance study, and the ENG; $196.00 for x-rays; $2.80 for drugs; $15.50 for the electrocardiogram; and $54.00 for physical therapy.

On December 10, 1979, an informal review of the fiscal intermediary's decision partially denying CHAMPUS cost-sharing was requested. In that request, the sponsor stated that during the past few years the beneficiary had periodically received exhaustive diagnostic tests and procedures on an outpatient basis. On July 19, 1979, the beneficiary was examined on an outpatient basis and was told that she would have to be treated as an inpatient for diagnostic testing procedures that could not be performed on an outpatient basis. He further stated that once admitted to the hospital the beneficiary's daily schedule was controlled, and testing could not have been done on an outpatient basis. It was asserted that, if the diagnostic tests and procedures were to be conducted by this facility on an outpatient basis, the beneficiary would have had to commute 200 miles daily. Further, the sponsor noted that the supplemental insurer, Blue Cross/Blue Shield of , paid its portion of the medical coverage and recognized all charges listed as proper and justified.

On March 13, 1980, the CHAMPUS Fiscal Intermediary informed the sponsor that an informal review was performed and the services were once again denied. The informal review decision upheld the initial determination on the basis that the CHAMPUS regulation specifically excludes services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been routinely performed on an outpatient basis. This decision held that the diagnostic x-ray, laboratory and pathological services, and machine tests performed during the beneficiary's admission were medically necessary and would have been covered if performed on an outpatient basis; thus, CHAMPUS benefits were extended for those procedures only and cost-shared on an outpatient basis. This decision upheld the previous decision and allowed payment for the tests conducted during the inpatient stay; however, the fiscal intermediary continued to deny the hospital care and food services.

As a result of this determination, the matter was again appealed. In support of this appeal, the sponsor provided a statement from the attending physician which stated that the patient was admitted to this hospital because of multiple medical problems which required complex diagnostic procedures, close monitoring of pertinent clinical parameters, observation of diet during investigational procedures and therapy, and close supervision of implemented therapy including the response to medications. The Medical Director for the fiscal intermediary reviewed the case, including the new information from the attending physician, and determined that the inpatient care was primarily to perform diagnostic tests and procedures which could have been performed on an outpatient basis without adversely affecting the patient's condition or quality of care. Coverage of the hospitalization and food services was once again denied.

Based on this decision, the beneficiary and sponsor requested OCHAMPUS review. Prior to issuing a decision, OCHAMPUS referred the case file to the Colorado Foundation for Medical Care for review and evaluation. The medical review was conducted by two physicians, both of whom have medical specialties in internal medicine. One is certified by the American Board of Preventive Medicine; the other physician is a specialist in occupational medicine. Both physicians are involved in direct patient care. Based on their review, these physicians opined that this beneficiary was not in an acute phase of illness which required hospitalization. In their opinions, hospital admission was not medically necessary. Also, they opined that all of the routine studies and consultations provided to the beneficiary while an inpatient could have been accomplished on an outpatient basis. They indicated that the records show the patient, although hospitalized, was treated at the medical specialty clinics for the tests and consultations just as if she was an outpatient. They also questioned the purported need for close medical monitoring and supervision of this beneficiary in that the

medical records show that the patient was allowed to take her own medication and close monitoring and supervision were not documented in the chart. Finally, they opined that, based on the admission history, the beneficiary's admitting physical, the types of studies conducted, and the fact the consultations were all conducted in the medical specialty clinics, inpatient care was inappropriate for conducting these tests and consultations.

Based on the hospital notes, discharge summary, and the opinions of the reviewing physicians, the OCHAMPUS First Level Appeal Decision held that CHAMPUS could not cost-share the inpatient charges for room, board, and the meal tickets for the period of July 21, 1979, through August 1, 1979. The reason for this decision was the fact that the file does not evidence the medical necessity for the inpatient services and supplies.

As a result of this decision, the sponsor and beneficiary requested a hearing. A hearing was held by William E. Anderson, Hearing Officer, on October 21, 1981, and the Hearing Officer has issued his Recommended Decision. All prior levels of administrative review have been exhausted and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether the inpatient costs for room and board and meal tickets for the beneficiary's inpatient stay at University Medical Center from July 21, 1979, through August 1, 1979, is authorized care under CHAMPUS. In resolving this issue, it must be determined whether the inpatient admission was medically necessary and at the appropriate level of care.

Medical Necessity/Appropriate Level Care

The Department of Defense Appropriations Act, 1979, Public Law 95-457, prohibits the use of CHAMPUS 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 restriction has consistently appeared in each subsequent Department of Defense Appropriation Act.

Department of Defense Regulation DoD 6010.8-R in chapter II, B.104, defines medically necessary under CHAMPUS as:

> ". . . the level of services and supplies (that is, frequency, extent, and kinds) adequate for the diagnosis and treatment of illness or injury . . . . Medically necessary includes concept of appropriate medical care."

Under these statutory and regulatory provisions, the inpatient care in question must be found to be medically necessary (essential) and appropriate for the care or treatment of a diagnosed condition.

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

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

Finally, the CHAMPUS regulation, DoD 6010.8-R, chapter IV, G.4, specifically excluded from coverage certain diagnostic admissions as follows:

> "Diagnostic Admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been, and routinely are, performed on an outpatient basis. Note: If it is determined that the diagnostic x-ray, laboratory and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis."

There is no dispute over the medical necessity or appropriateness of the diagnostic tests provided to the beneficiary from July 21, 1979, through August 1, 1979, at University Medical Center. The case records adequately document the patient's medical history, therapeutic intervention and observations, and symptoms which required diagnostic testing and evaluation. The issue remains, however, whether the diagnostic testing and evaluation "could have been, and routinely are, performed on an outpatient basis." If so, then the diagnostic hospital admission was not medically necessary or appropriate and is specifically excluded from CHAMPUS coverage.

At the hearing, the beneficiary submitted a statement from the attending physician prepared 3 days prior to the hearing. That statement contains the following information:

> "I have followed [the beneficiary] for a number of years because of multiple medical problems. These problems have been dealt with in the main by outpatient visits, appropriate therapeutic intervention and observations, at the time of these visits, of responses. In 1979 I admitted her to Duke Hospital because in addition to medical problems that had been carefully assessed and treated earlier she had developed new and troublesome symptoms that had not been adequately sorted out on an outpatient basis. These symptoms included nonspecific chest discomfort, multiple episodes of acute vertigo, weakness of the lower extremities and severe neck and back pain. The discomfort in the neck and adjacent upper back was severe enough as to very significantly limit activities. In the course of that hospitalization this problem was evaluated closely by neurologic and orthopedic surgical consultants. Medical management was elected for the present. As is noted in the accompanying consultation note by Dr. the problem has continued to be severe and the question of a surgical intervention arises again, as was the case in 1979. Hospital management included physical therapy in addition to dietary interventions and adjustments of medications for multiple medical problems.
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> "I believe the issue of hospitalization can readily be justified, on the basis of the issues raised then and subsequently."

The consultation note referenced in the attending physician's statement involves a neurological examination conducted 6 months after the patient's hospitalization under appeal. It was this consultant's opinion that the patient, by history, had significant and severe neck pain, including a "severe continuing muscle spasm which may be due to underlying cervical spondylosis."

In summary, it was the beneficiary's testimony at the hearing that she had been treated by the attending physician on an outpatient basis for years. During the 2½ months prior to hospitalization, she had been suffering serious vertigo attacks and had been unable to perform her work as a field agent for the

Internal Revenue Service. She was unable to drive a car due to her medical problems and would not have been able to commence the 100-mile round trip between her residence and . University Medical Center on a daily basis.

The beneficiary also testified that she was admitted to the Drake Pavilion during her care a University Medical Center. According to her, the Drake Pavilion consists of two floors of rooms at the Inn which are used to house patients not requiring 24-hour observation. The Pavilion always has a nurse on duty at the nurses' station on each floor, and the physician's assistant made two trips daily to talk to the beneficiary. Shuttle buses transport patients to and from the Medical Center. The beneficiary used the shuttle buses to keep appointments at the Medical Center clinics and then returned to her room for bed rest until the next appointment. The beneficiary stated that the nurses did not provide nursing services in the patient's room, but communicated with the patient by telephone or when the patient walked down to the nurses' station. Finally, it was noted that the patient received a meal ticket which enabled her to eat her meals in the main cafeteria.

Based on the hearing record, the Hearing Officer found that the beneficiary's diagnostic tests and evaluations could have been, and normally are, performed on an outpatient basis. After a thorough review of the record, I concur with the Hearing Officer's finding and adopt it as my finding in this case. Despite the attending physician's statements that the patient required hospitalization for close monitoring of pertinent clinical data, observation of diet during investigational procedures and therapy, and close supervision of implemented therapy including response to medications, the medical records fail to support his statements. I agree with the medical reviewers from the Colorado Foundation for Medical Care who opined that the patient was not in an acute phase of illness requiring hospitalization; the patient was treated at the Medical Center's clinics as if she was an outpatient; the medical records indicate the patient was allowed to take her own medication without close monitoring or supervision; and the tests and consultations could have been performed on an outpatient basis.

Whether the patient could have safely commuted the 100 miles between her residence and the Duke University Medical Center is not pertinent to the issue of appropriate care in this case. The beneficiary elected not to seek medical care in her hometown, but opted for treatment at the Duke University Medical Center. Having made such a choice, it is obvious that temporarily living near the treating facility during the period of diagnostic testing was safer and more convenient. Had the patient obtained private living accommodations (e.g., a hotel room) the cost of such accommodations would not have been cost-shared as medical care under CHAMPUS. Although she stayed in the Drake Pavilion to

the Duke University Medical Center, the records do not support a finding that the accommodations were medically necessary as a diagnostic admission under the CHAMPUS regulation.

As a result of my review, I find that the record fails to document the medical necessity of the inpatient care at Drake Pavilion, Duke University Medical Center, from July 21, 1979, through August 1, 1979. As has been indicated, this beneficiary may have required some diagnostic treatment; however, inpatient care in this hospital was not essential for these diagnostic tests. As opined by the reviewing physicians, the patient should have been referred for these diagnostic tests on an outpatient basis. The inpatient care does not meet the requirements of the Department of Defense Appropriation Acts nor the CHAMPUS regulation and is not authorized CHAMPUS care.

SECONDARY ISSUE

Medical Review

The beneficiary expressed concern with the decision to deny care recommended by her treating physician, based on medical review of the records. While the treating physician may be in the best position to assess the need for treatment, it is incumbent on that physician to document the medical records in support of his recommended treatment plan. Under the CHAMPUS regulation, the burden is on the party requesting payment of care to document adequately his claim to enable CHAMPUS officials to determine if the care is authorized and payable under CHAMPUS.

Review of records by medical consultants is a useful method of determining if the medical documentation is adequate and if the care is in keeping with generally acceptable norms for medical practice in the United States. The opinions of such medical consultants do not control the ultimate agency decision; rather, the opinions are evaluated in conjunction with the other evidence in the hearing record.

In this appeal, the beneficiary was given the additional opportunity to submit information from her attending physician to rebut the opinions of the medical reviewers. Although the hearing record was held open 20 days following the hearing for submission of such information, none was received. While the treating physician may have recommended hospital admission in this case as being in the best interest of the patient, the record fails to establish the medical necessity of such admission under the CHAMPUS criteria for cost-sharing such claims.

As noted by the Hearing Officer, review by medical consultants is quite useful and necessary for both quality control and cost containment. In addition, I find such reviews necessary to enable me to meet my responsibility to cost-share CHAMPUS claims as authorized by law or regulation.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the inpatient care (room and board and meal ticket) at , University Medical Center for the dates July 21, 1979, to August 1, 1979, be denied CHAMPUS cost-sharing as the care was not medically necessary and was above the appropriate level of care. Therefore, the claims for hospitalization for this period and the beneficiary's appeal are denied. The diagnostic tests are deemed to be medically necessary and have been cost-shared by CHAMPUS on an outpatient basis. 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