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) File 83-32
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS appeal OASD(HA) Case File 83-32 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the beneficiary, a retired officer in the United States Air Force. The appeal involves the question of CHAMPUS coverage of inpatient care for alcoholism provided the beneficiary from November 9, 1980, to December 8, 1980. The total hospital charge of $3,781.51 incurred by the beneficiary was denied by CHAMPUS because the inpatient care was not medically necessary and was provided at an inappropriate level of care.

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 Recommendation that the denial of CHAMPUS cost-sharing for inpatient care from November 9, 1980, to November 30, 1980, be reversed on the basis that the beneficiary, at the time of his admission, was suffering from the medical effects of acute alcoholism and, therefore, an inpatient hospital setting was medically necessary and the appropriate level of care. The Hearing Officer, however, recommends that the denial of CHAMPUS cost-sharing for inpatient care from December 1, 1980, until the patient's discharge on December 8, 1980, be upheld on the basis that the hospitalization for this period was not medically necessary and was above the appropriate level of care. The Director, OCHAMPUS, agrees with the Hearing Officer's Recommended Decision and recommends its adoption as the FINAL DECISION.

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 recommendations of the Hearing Officer and Director, OCHAMPUS, to allow CHAMPUS cost-sharing of the

inpatient care from November 9, 1980, through November 30, 1980, and to deny CHAMPUS coverage of the inpatient care from December 1, 1980, to December 8, 1980.

The Assistant Secretary of Defense (Health Affairs) adopts the recommendation of the Hearing Officer and Director, OCHAMPUS, as the FINAL DECISION. The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to allow CHAMPUS cost-sharing of inpatient hospitalization at CareUnit Hospital (formerly Alcenas Hospital) from November 9, 1980, through November 30, 1980, but deny CHAMPUS cost-sharing of inpatient hospitalization at CareUnit Hospital from December 1, 1980, to December 8, 1980. This decision to deny CHAMPUS cost-sharing of inpatient hospitalization from December 1, 1980, to December 8, 1980, is based on findings the care provided was not medically necessary. Further, the hospitalization for the period was at an inappropriate level of care.

FACTUAL BACKGROUND

The beneficiary was admitted to Hospital (formerly Hospital), , , on November 9, 1980, with a primary diagnosis of acute and chronic alcoholism and other substance abuse and a secondary diagnosis of feet problems. The treatment facility records reveal the beneficiary, upon admission, was well-developed, well-nourished, alert, somewhat agitated but in no acute distress; vital signs were normal. The physician's history indicates the beneficiary began using alcohol at age 45 and drank approximately 1 liter of wine per day. The beneficiary denied any hallucinations or seizures but experienced blackouts.

The beneficiary was placed in a detoxification unit upon admission and was transferred to the regular care unit on November 14, 1980. During detoxification, the patient was given Adrenal, Cortex, Pyridoxine, Hydrochloride, Cyanocobalamin, Solu-B-Forte, NatraCal, and magnesium sulfate. The beneficiary was also prescribed Librium as a sedative and Meprobamate for the pain in his feet. The beneficiary's course of treatment in the hospital was generally uneventful; however, he would frequently complain of pain in his feet. In addition to this hospitalization, the beneficiary previously received treatment for alcoholism at , , where he was hospitalized in its alcohol program.

Upon admission, the hospital conducted an assessment of the beneficiary. In that assessment, the registered nurse examiner indicated the beneficiary suffered from acute and chronic alcoholism and other substance abuse, nutritional deficiencies, chronic diarrhea for many years, glaucoma, gastric ulcer, partial gastrectomy with dumping syndrome, peripheral neuropathy, porphyria, allergies to penicillin and to antabuse, and feet problems.

The physician's orders of the hospital indicate that beginning with admission the patient was prescribed Librium, Niacinamide, Colestid, and Timoptic. The physician also instructed that the beneficiary not be given vitamin C. The remainder of the physician's orders primarily involve the prescription of vitamins, granting permission to consult with other physicians, substituting various foods, scheduling of x-rays, EEG, CT scan, consultation with the podiatrist, and nerve conduction studies.

On admission, the beneficiary received routine lab work, including CBC with indices, urinalysis, Multi-chem Screen, BDRL, hair analysis, Glucose Tolerance Test, and a PPD test. The daily nurses' notes indicate the hospital stay of the beneficiary was generally uneventful and that the beneficiary received medications as prescribed by the attending physician, displayed some displeasure with being in the facility, and complained of pain in each foot.

The treatment regimen of the hospital consisted of lectures, consultations, rest, and receiving the prescribed medications. The nursing notes indicate that on November 14, 1980, the beneficiary was removed from detoxification and placed in the second level, i.e., rehabilitative level of the treatment program. The nursing notes indicated that during the initial period of hospitalization, the beneficiary was abrupt in manner, argumentative, occasionally became disoriented and somewhat confused as to the treatment program, and still complained of discomfort and pain in his feet. These notes also indicate the beneficiary exhibited a poor attitude toward the treatment. On November 19, 1980, the nursing notes indicate the beneficiary appeared to be more cheerful, more aware of his surroundings, more aware of his treatment program, and more cooperative. On November 29, 1980, the nursing notes indicate the patient was out on pass for the afternoon and evening with his family. On December 7, 1980, the patient was once again out on pass for most of the day. On December 8, 1980, the patient, apparently feeling that he had derived the maximum benefit from the program, discharged himself against medical advice.

At the beginning and throughout the course of hospitalization, the patient complained of pain in his feet. As a result of this, he was treated by a podiatrist. The beneficiary was diagnosed as having hyperpronation of both feet, and the podiatrist provided casting for the arches of his feet. The attending physician noted that at the time of discharge there seemed to be improvement of both feet.

The discharge diagnoses were: (1) acute and chronic alcoholism, (2) nutritional deficiencies, (3) chronic diarrhea, (4) glaucoma, (5) partial gastrectomy with dumping syndrome, (6) peripheral neuropathy, (7) porphyria, (8) history of gastric ulcer, (9) allergy to penicillin and antabuse and, (10) hyperpronation of both feet. The discharge summary further indicated that this was a first admission for the patient at this facility and that he appeared to be in no acute distress at the time of discharge.

The alcohol history indicates that this patient, at age 45, started drinking wine at the rate of 1 liter per day. He experienced blackouts but had no change in his tolerance. He was previously treated at , ., in 1979 in its alcohol program. The laboratory tests indicated that everything was within normal limits and unremarkable. The treatment course indicated that the patient had a slow detoxification but his strength improved and, at the time of discharge, the patient was feeling better, including a decrease in pain to his feet. The treating physician indicated that he wanted the beneficiary to stay a week longer for treatment. He felt the beneficiary, at the beginning of hospitalization, was not in the program because of his alcohol problem but rather for the pain in his feet and had not fully benefited from the rehabilitation program. At the time of discharge, the patient seemed to be feeling much improved, although he still complained of some pain in his feet. The prognosis for his sobriety was fair.

On December 8, 1980, the provider submitted a claim to the CHAMPUS Fiscal Intermediary covering the 28-day period of hospitalization from November 9, 1980, to December 8, 1980, in the amount of $3,781.51. On January 23, 1981, the fiscal intermediary, after applying the appropriate deductibles and cost-share amounts, issued payment to the provider in the amount of $2,311.13, for the first 21 days of care. The provider was also informed that the last 7 days of hospitalization were not cost-shared by CHAMPUS. On May 13, 1981, the Acting Medical Director, CareUnit Hospital, informed the fiscal intermediary of the philosophy of the provider and the basis for requiring a 28-day hospitalization. The Acting Medical Director stated that:

> "The philosophy of a four week program is as follows: In the early stages of recovery the patient must recover from the acute effects of alcoholism, i.e., the central nervous system toxicity to allow clearing of mental functions. Then in the second phase of recovery the patient can begin to put together a program of longterm sobriety and begin to address some of the problems caused by the drinking. Ideally patients need three or four weeks for the second phase alone; thus, we request persons who are very ill at the time of admission or who have a prolonged detoxification course to stay longer than the minimum four weeks."

This letter did not specifically indicate the medical necessity for the additional 7 days of inpatient stay; therefore, the fiscal intermediary requested documentation of the medical necessity. On August 3, 1981, the participating provider responded as follows:

> "[The beneficiary] had experienced severe foot pain and was on several drugs for this problem prior to admission. He also had a long standing dumping syndrome from a prior gastrectomy. Both these problems interfered with sleeping at night and distracted him from the rehabilitation aspects of the program for the first three weeks of treatment.
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> "[The beneficiary] was evaluated by . . . [a neurologist] on November 17, 1980, who noted painful and numb feet with pain out of proportion to physical findings of neuropathy. In addition, ataxia and questionable mild dementia were noted. Further workup by a podiatrist resulted in the diagnosis of hyperpronation of both feet; the resultant corrective footwear gave him relief from the pain.
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> "[The beneficiary] was mentally slow to clear and focused on his medical complaints, and was in denial of alcoholism for the first three weeks of treatment. It was recommended by the counseling and medical staff that he complete a fifth week of treatment because of his overall deteriorated condition on admission and slow progress in recovery. There was concern that four weeks had not been sufficient time for [the beneficiary] to internalize a program for sobriety. He refused to stay the fifth week, however."

The beneficiary requested the fiscal intermediary review its decision denying the last 7 days of hospitalization. The fiscal intermediary's informal review decision, issued on October 27, 1981, indicated its medical review department had opined the beneficiary's claim was processed and paid correctly because the medical necessity of treatment beyond the first 3 weeks had not been established. At the reconsideration review level, the fiscal intermediary upheld its prior decision to limit CHAMPUS benefits for the hospitalization to the initial 21 days and denied benefits for the remaining 7 days. The beneficiary then appealed to OCHAMPUS for a First Level Appeal determination, and the case was referred to the American Psychiatric Association for medical review.

The reviewing physician for the American Psychiatric Association is certified as a Diplomate in Psychiatry and a Diplomate, American Board of Quality Assurance and Utilization Review. In reviewing this case, the reviewing psychiatrist noted that the beneficiary, when admitted to the CareUnit Hospital, did not display the symptoms common to patients admitted to hospitals of this nature; e.g, vomiting, hemoptysis, convulsions, severe

dehydration, severe gastritis, severe tremors, marked anorexia, and cranial contusions. He did note that there was a slight elevation of blood pressure on admission; however, it was rapidly controlled. Further, the reviewing psychiatrist noted that the admission nursing notes indicated no symptoms of alcoholism or complaints, and the physical examination of the beneficiary, conducted on the day following admission, indicated that he was not in acute distress. Based on this documentation and evidence, the reviewing psychiatrist was unable to find any documentation at the time of admission that the patient was, in fact, in the acute stages of alcoholism or that he was even actually intoxicated. Therefore, the reviewing psychiatrist concluded the beneficiary was not in an acute stage of alcoholism when admitted.

The reviewing psychiatrist also opined that, at the time of admission, the inpatient setting was not medically necessary for detoxification. Although the beneficiary was mildly belligerent and somewhat confused when admitted, these are temporary symptoms which could have been managed at home if there was someone in attendance. If there was no one to care for the beneficiary at home, then the acute hospital setting might be marginally acceptable, but only for the dates of November 13 through November 15, 1980.

The reviewing psychiatrist was also requested to address the issue of whether or not the inpatient setting was medically necessary when the beneficiary was removed to the rehabilitation phase of the alcoholic treatment. In response to this question the reviewing psychiatrist stated:

> "Firstly, I would not have anticipated that this patient would do well in an outpatient alcoholic rehabilitation program. Therefore, if it is judged that he has significant rehabilitation potential, an inpatient alcoholic rehabilitation program would be the proper setting. However, I find very little to indicate that this is an appropriate rehabilitation admission. In fact, I do not find this issue even dealt with in the record. It would seem that the fact that this patient had an alcoholic problem was sufficient reason in the mind of the admitting physician to admit him. I do not concur with that attitude. Rehabilitative services, whether alcohol, pain, cardiac, pulmonary or physical medicine, require for admission evidence that the particular patient has a high likelihood of responding to an intensive, multi-disciplinary rehabilitative effort. I find no documented evidence to support that view regarding this patient. Consequently, I am not surprised that this patient did not do well in the

> program. My answer to this question is: The inpatient setting was not medically necessary for the reason that there is no documentation to support the rehabilitation criterion that there must be reason to believe that this particular patient at this particular time will respond favorably to the rehabilitation program."

It was also the opinion of the reviewing psychiatrist that the beneficiary did receive active medical treatment during both the detoxification and rehabilitation phases of the treatment; however, he also noted that the alcoholic rehabilitation services were not fully documented. The reviewing psychiatrist also rendered an opinion as to whether or not more than 21 days of inpatient treatment for alcoholism were medically necessary. It was the opinion of the reviewing psychiatrist that this beneficiary did not require more than 21 days of inpatient treatment. This opinion was based on the lack of documentation indicating any day-to-day progress of the beneficiary. For instance, the reviewing psychiatrist indicated that there were no weekly rehabilitation team summaries. The counseling summary was completed on the day of discharge and, therefore, does not adequately reflect any progress during the treatment phase of the hospitalization. This psychiatrist also noted the patient was displeased with Alcoholics Anonymous, did not attend all activities, was not accepting his reading assignments, had no understanding of alcoholism, and had little real internalization. It appeared that he was more concerned with the pain in his feet than with his alcoholism and left the facility against medical advice.

According to the reviewing psychiatrist, if this beneficiary was deemed to be an appropriate candidate for rehabilitation (which he states this beneficiary was not) but then showed the attitudes and behavior as indicted in the record, the staff should have 4 to 7 days to attempt to change those attitudes. If unsuccessful, the patient should have been promptly discharged. In his opinion, the reviewing psychiatrist estimated that this beneficiary, if he had been an appropriate candidate of the rehabilitation program, should have been discharged around November 26, 1980. Finally, the reviewing psychiatrist noted that there were no serious physical complications that would otherwise require an inpatient stay.

Based on the findings and opinions of the reviewing psychiatrist, the OCHAMPUS First Level Appeal decision found the inpatient hospitalization for the beneficiary's alcoholic detoxification and rehabilitation program from November 9, 1980, to December 8, 1980, to be not medically necessary treatment for the beneficiary's alcoholic condition. This decision was based on a determination that acute alcoholism had not been established and the rehabilitation program did not require an inpatient stay. Therefore, all benefits paid by the fiscal intermediary were paid in error.

The beneficiary appealed and requested a hearing. In connection with that appeal, the beneficiary submitted a letter from the Medical Director of the provider. This letter took issue with the findings of the American Psychiatric Association's reviewing psychiatrist. The Medical Director for the provider contends the beneficiary was in an acute distress upon admission. In support of this assertion the Medical Director states:

> "[The beneficiary] suffered from the acute stages of alcoholism, aggravated by poor bowel function and dumping syndrome due to prior gastric resection. He had also suffered a relapse because of pain medications and sleeping pills, including Prolixin, Dalmane, Meprobamate and Codeine, which were prescribed at the Mason Clinic to give relief from progressive foot pain diagnosed as polyneuropathy. He thus presented as a man with acute alcoholism and the resultant acute brain toxicity of alcoholism with anxiety, memory problems, poor judgment, reasoning and insight. In addition, he had difficulty walking due to foot pain and objected to being withdrawn from pain medications, as was necessary in order to achieve lasting sobriety. His dumping syndrome was also aggravated by alcohol use with diarrhea, up to ten times per day.
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> "The term 'acute distress' is used in our facility to describe conditions of acute respiratory difficulty, acute cardiac problems of an urgent nature, active GI bleeding, et cetera - conditions which would warrant transfer to an intensive care unit. Thus 'no acute distress' implied [the beneficiary] could be safely detoxified in the medical wing of the CareUnit Hospital of Kirkland. Thus [the beneficiary] suffered from acute alcoholism without being in danger of immediate death. Judicious management of his detoxification with Librium, IV fluids and vitamin and mineral replacement prevented the occurence of the full-blown withdrawal syndrome, which would be expected to otherwise develop in the 24 hours after his admission.
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> "We do not believe that we have to wait for the onset of a convulsion or other serious medical complications to begin treatment for alcohol withdrawal. Indeed adequate use of sedation with careful monitoring prevents early patient AMA discharges. On the fifth

day of treatment at 1:00 A.M., while still on Librium, [the beneficiary] asked for his belongings and attempted to leave treatment but was talked down by the nursing staff. At the time he was still shaky and had slow mentation. Thus the supportive hospital environment prevented an untimely AMA discharge.

"For the next week the nursing notes continued to describe the patient as intermittently shaky, anxious and confused, both as to where and why he was in treatment and confused about the scheduled events for the patients. He at times exhibited inappropriate behavior such as walking nude in his room with an open door. His slow mentation, slow central nervous system clearing, and painful feet were indications for a neurological examination. He was seen by [a neurologist] on November 17 with findings of painful and numb feet, ataxia, loss of peripheral vision, history of porphyria and questionable mild dementia. B-vitamin malnutrition with resultant polyneuropathy, ataxia, and dementia would be consistent with the history of alcoholism and dumping syndrome induced malabsorption.

"Thus the diagnosis of acute alcoholism, based on all available data, meets the requirements of the generally accepted norm for the medical practice of alcoholism, not only at the alcoholism hospitals in this state but in alcoholism hospitals throughout the country.

"In regard to the 'ancillary medical problems,' the patient presented himself not only suffering from acute alcoholism but from other medical problems which were addressed during the course of treatment. Dumping syndrome induced malabsorption undoubtedly aggravated B-vitamin insufficiency in this alcoholic man. The severe foot pain and difficulty walking were not ancillary problems but had been a key to his relapse from sobriety and subsequently had to be addressed to enable the patient to achieve longlasting sobriety.

"Those ancillary medical problems were covered in his hospitalization coverage. As a hospital, we felt responsible to respond to those problems impacting the patient, his

> relapse and his recovery. These areas did impact on his progress through the course of his alcoholism treatment and his subsequent two years of sobriety and return to normal function."

A hearing was held at , , on June 8, 1983, before , Hearing Officer. The beneficiary was represented by counsel at the hearing and prior to the hearing submitted a hearing brief. Present at the hearing were the beneficiary, his spouse and his attorney, a representative from the hospital, the hospital Medical Director, and Dr. , the beneficiary's son-in-law.

At the hearing, the beneficiary testified concerning his medical history, including the medical problems which he has encountered since the date of his treatment at the CareUnit Hospital. Specifically, the patient testified concerning his reasons for admission and stated that just prior to this admission he was experiencing severe pain in his feet causing him to contemplate suicide.

Dr. testified at the hearing as an interested relative. Dr. is a pediatrician and the son-in-law of the beneficiary. This physician testified that approximately 2 to 3 months before hospitalization at the CareUnit Hospital, the beneficiary called his home and indicated that he may commit suicide. This individual testified based on his knowledge of the beneficiary and the beneficiary's drinking habits, his review of the case, and the CHAMPUS requirements. He opined that at least 1 month prior to admission this beneficiary was suffering from all six of the alcoholic admission criteria set forth in the CHAMPUS regulation; i.e., delirium, confusion, severe malnutrition, trauma, inability to function, and unconsciousness. It was the opinion of this physician that the beneficiary was in the acute phase of alcoholism.

The beneficiary's wife testified at the hearing. Her testimony detailed the circumstances leading up to the hospitalization. She specifically mentioned the physical condition of the beneficiary and stated that prior to admission her husband appeared confused, exhibited an inability to function, lapsed into unconsciousness because of drinking, exhibited some signs of delirium, and appeared to be malnourished. The beneficiary's spouse also testified that during the course of hospital treatment she checked with OCHAMPUS (not specifying the individual) and the hospital concerning the fourth week of inpatient care. It was her understanding that CHAMPUS would cost-share this week and had, in fact, cost-shared for the fourth week of care for other beneficiaries in the past.

The Medical Director for the hospital also testified at the hearing. This physician stated the primary diagnosis was chronic overuse of alcohol to the point of 1 gallon of wine per day. This physician concluded that the beneficiary was alcoholic

because of his history of alcohol abuse and because he continuously returned to the use of alcohol regardless of consequences to his own health. In her opinion, inpatient treatment was medically necessary for the beneficiary and he could not have been managed as an outpatient. The Medical Director further detailed the general program of the CareUnit Hospital. She indicated the detoxification course for the beneficiary was longer than normally used at this facility because of the nature and the extent of the beneficiary's alcoholism. Further, the beneficiary had a longer period of withdrawal than the usual patient.

This physician also discussed the specific medical problems of the beneficiary, the extensive period of detoxification and the relatively short period of rehabilitation. The Medical Director indicated that because of the short period of rehabilitation, the hospital wanted to extend the inpatient care to give the beneficiary the full benefits of the rehabilitative program. This physician expanded on the comments of the American Psychiatric Association's reviewing psychiatrist, specifically addressing the issue of whether or not the patient, upon admission, was in an acute stage of alcoholism. In her opinion, the beneficiary was in an acute stage of alcoholism. She explained the CareUnit Hospital, when using the term "acute," used the term to refer to a medical condition that would prevent a patient from entering into the CareUnit Hospital. For instance, if there is an acute respiratory problem or similar problem then it would be inappropriate to admit the patient. However, it was her opinion that this beneficiary was in an acute stage of alcoholism upon admission and admission to the CareUnit Hospital was medically necessary.

The Hearing Officer has submitted her Recommended Decision. All prior levels of administrative appeal have been exhausted and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are whether the inpatient hospitalization for treatment of alcoholism was (1) medically necessary, and (2) at the appropriate level of care for the treatment of alcoholism.

Medically Necessary

Under the CHAMPUS regulation, DoD 6010.8-R, chapter IV, A.1., the CHAMPUS Basic Program will cost-share medically necessary services and supplies required in the diagnosis and treatment of illness or injury, subject to all applicable limitations and exclusions. Services which are not medically necessary are specifically excluded (chapter IV, G.1.). Under chapter II, B.104, medically necessary is defined as:

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

This general concept of "medically necessary" is further defined in relation to the extent of CHAMPUS coverage of inpatient care for alcoholism by DoD 6010.8-R, chapter IV, E.4., as follows:

"4. Alcoholism. Inpatient hospital stays may be required for detoxification services during acute stages of alcoholism when the patient is suffering from delirium, confusion, trauma, unconsciousness and severe malnutrition, and is no longer able to function. During such acute periods of detoxification and physical stabilization (i.e., "drying out") of the alcoholic patient, it is generally accepted that there can be a need for medical management of the patient, i.e., there is a probability that medical complications will occur during alcohol withdrawal, necessitating the constant availability of physicians and/or complex medical equipment found only in a hospital setting. Therefore, inpatient hospital care, during such acute periods and under such conditions, is considered reasonable and medically necessary for the treatment of the alcoholic patient and thus covered under CHAMPUS. Active medical treatment of the acute phase of alcoholic withdrawal and the stabilization period usually takes from three (3) to seven (7) days.

" a. Rehabilitative Phase. An inpatient stay for alcoholism (either in a hospital or through transfer to another type of authorized institution) may continue beyond the three (3) to seven (7) day period, moving into the rehabilitative program phase. Each such case will be reviewed on its own merits to determine whether an inpatient setting continues to be required.

"EXAMPLE"

"If a continued inpatient rehabilitative stay primarily involves administration

of antabuse therapy and the patient has no serious physical complications otherwise requiring an inpatient stay, the inpatient environment would not be considered necessary and therefore benefits could not be extended.

" b. Repeated Rehabilitative Stays: Limited to Three (3) Episodes. Even if a case is determined to be appropriately continued on an inpatient basis, repeated rehabilitative stays will be limited to three (3) episodes (lifetime maximum); and any further rehabilitative stays are not eligible for benefits. However, inpatient stays for the acute stage of alcoholism requiring detoxification/stabilization will continue to be covered. When the inpatient hospital setting is medically required, a combined program of detoxification/stabilization and rehabilitation will normally not be approved for more than a maximum of three (3) weeks per episode.

" c. Outpatient Psychiatric Treatment Programs. Otherwise medically necessary covered services related to outpatient psychiatric treatment programs for alcoholism are covered and continue to be covered even though benefits are not available for further inpatient rehabilitative episodes, subject to the same psychotherapy review guidelines as other diagnoses."

Therefore, under CHAMPUS, coverage of inpatient treatment of alcoholism consists of a detoxification phase from 3 to 7 days followed by a rehabilitation phase. The combined program will not normally be approved for more than a maximum of 3 weeks per episode. As previously determined in FINAL DECISIONS OASD(HA) 02-80, 04-80, and 82-10, however, the presence of severe medical effects of alcohol determine if the rehabilitative phase is authorized on an inpatient basis beyond the normal 21-day limit.

The medical records in this appeal indicate the beneficiary was treated for the pain in his feet. However, it should be noted that the treatment for the pain in the beneficiary's feet was not sufficient to justify hospitalization. This opinion is concurred in by the Medical Director of CareUnit Hospital.

The Hearing Officer found the beneficiary's inpatient care from November 9, 1980, through November 30, 1980, to be medically necessary. The Hearing Officer's decision is based, as indicated in the Recommended Decision, on the testimony presented at the hearing by the two physicians.

In reviewing the appeal record, I have noted the testimony of the Medical Director of the treating facility, the testimony of the beneficiary's son-in-law (a pediatrician), the testimonies of the beneficiary and his spouse, the medical review conducted by the American Psychiatric Association, and the Recommended Decision of the Hearing Officer. From the evidence of record, I conclude that the hospitalization at the CareUnit Hospital from November 9, 1980, through November 30, 1980, was medically necessary because the beneficiary was suffering from acute distress at the time of admission. This has been adequately established by the testimony at the hearing; however, I do note that the medical records provided to OCHAMPUS for the First Level Appeal decision inadequately documented the medical necessity of the inpatient care. Further, I concur with the findings of the Hearing Officer that the final 7-day period of hospitalization from December 1, 1980, until the discharge of the patient on December 8, 1980, was not medically necessary and could have been performed on an outpatient basis. There is no indication and no evidence provided in the record or at the hearing to justify continued need for an inpatient stay beyond the normal 21 days. Specifically, there has been no evidence introduced to indicate the existence of severe medical effects of alcohol which medically require a continued inpatient setting.

In summary, I find the inpatient treatment to be medically necessary for the treatment of alcoholism and within the CHAMPUS regulatory criteria from November 9, 1980, through November 30, 1980 (21 days). Further, I find the inpatient treatment from December 1, 1980, to December 8, 1980, to be not medically necessary. The record supports CHAMPUS coverage for the normal period authorized by the Regulation for treatment of alcoholism. I further adopt, as indicated above, the findings of the Hearing Officer regarding the failure to document the presence of a physical complication that required inpatient care beyond November 30, 1980. Therefore, I find the inpatient care from December 1, 1980, to December 8, 1980, not to be medically necessary and not within the CHAMPUS criteria for coverage of inpatient care for alcoholism. CHAMPUS cost-sharing of the inpatient care from December 1, 1980 to December 8, 1980, is denied.

Appropriate Level of Care

Under the CHAMPUS regulation, DoD 6010.8-R, chapter IV, B.1.y, the level of institutional care authorized under the CHAMPUS Basic Program is limited to the appropriate level required to provide the medically necessary treatment. Services and supplies related to inpatient stays above the appropriate level required to provide necessary medical care are excluded from CHAMPUS coverage.

The Hearing Officer found the inpatient stay beyond November 30, 1980, was not medically necessary and could have been provided on an outpatient basis. From the appeal record it appears that the primary reason for the continued hospitalization was the

treatment facility's philosophy of continuing inpatient care for a minimum of 28 days. The absence of physical complications requiring a continued inpatient stay beyond November 30, 1980, leads me to conclude that the inpatient setting was not required.

In view of the above, I adopt the Hearing Officer's finding that inpatient care beyond November 30, 1980, was not medically necessary and could have been provided on an outpatient basis. Therefore, the inpatient care beyond November 30, 1980, was above the appropriate level of care and thus excluded from CHAMPUS coverage.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the inpatient care from November 9, 1980, through November 30, 1980, was medically necessary and meets the CHAMPUS criteria for coverage of inpatient treatment of alcoholism. Further, I find the inpatient care from December 1, 1980, to December 8, 1980, was (1) not medically necessary as there were no physical complications associated with alcohol withdrawal that required inpatient treatment, and (2) above the appropriate level of care required for the treatment of alcoholism as care could have been provided on an outpatient basis. Therefore, the inpatient care subsequent to November 30, 1980, is not covered under CHAMPUS. The appeal of the beneficiary for this period of inpatient care is therefore denied. 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