ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

DEC 27 1983

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) FILE 83-45
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 83-45 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing parties are the beneficiary, a retired officer of the United States Navy, and the participating provider, Hospital, , . The appeal involves a claim for participation in a cardiac rehabilitation program by the beneficiary from February 10, 1982, to March 5, 1982, at Hospital. The amount billed for the cardiac rehabilitation program totals $385.00.

The hearing file of record, 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 First Level Appeal determination by OCHAMPUS denying coverage of the cardiac rehabilitation program be upheld. The Hearing Officer found that cardiac rehabilitation services were not medically necessary nor appropriate medical care under the CHAMPUS regulation and prior decisions and did not qualify as physical therapy under the physical therapy coverage of CHAMPUS. The Director, OCHAMPUS, concurs in these findings and recommends adoption of the Hearing Officer's Recommended Decision 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 recommendation of the Hearing Officer to deny CHAMPUS cost-sharing of the beneficiary's cardiac rehabilitation program 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 cost-sharing for the beneficiary's cardiac rehabilitation program from February 10, 1982, to March 5, 1982. This decision is based on findings that

the cardiac rehabilitation program (1) was not generally accepted medical practice and, therefore, was not medically necessary; (2) was not physical therapy; and (3) was, in part, an educational program and preventive care.

FACTUAL BACKGROUND

The beneficiary underwent quadruple coronary bypass surgery in December 1981. His physician subsequently referred him to the cardiac rehabilitation program at Imperial Point Hospital. The claim, which consisted of 11 sessions billed at the rate of $35.00 per session, was denied in full by the CHAMPUS Fiscal Intermediary on April 9, 1982.

The claim was resubmitted along with a March 4, 1982, letter from OCHAMPUS to the beneficiary that stated:

> "This responds to your recent correspondence concerning the coverage of cardiac rehabilitation programs under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
>
> "Coverage may be extended for special diagnostic tests and treatment procedures which generally consist of stress tests, pulmonary function tests and electrocardiography function. The extent of such coverage is on the basis of medical necessity. The regulation precludes payment for the other services such as the therapeutic exercise sessions and dietary counseling. Bills from cardiac rehabilitation centers cannot be submitted as a package. The professional services must be separately itemized. The CHAMPUS Fiscal Intermediary would have the responsibility of determining the appropriateness and level of care on a case-by-case basis."

In its April 30, 1982, letter resubmitting the claim, Medical Center enclosed an itemized statement and wrote that:

> "Per your letter stating that 'Bills from cardiac rehabilitation centers cannot be submitted as a package . . . . The $25.00 charge for Therapeutic sessions includes: Physical therapy assessment, and leading warm-up and cool down, dietary assessment and counseling, physician and nurse supervision of each exercise session, initial exercise prescription and revision once a week."

The itemization for the 11 sessions showed a $10.00 charge for ECG monitoring in addition to the $25.00 charge for each therapeutic exercise session.

By letter dated June 8, 1982, to Hospital, the fiscal intermediary reaffirmed the denial. The beneficiary then requested a reconsideration in a letter dated June 13, 1982. The fiscal intermediary, following its reconsideration, continued to deny CHAMPUS cost-sharing.

In a letter dated August 25, 1982, to the fiscal intermediary, , , M.D., Director, Cardiac Rehabilitation and Human Performance, Hospital District, , provided additional background in support of the beneficiary's request for CHAMPUS coverage of the cardiac rehabilitation program. (Imperial Point Hospital is part of the North Broward Hospital District.) Dr. wrote that:

> "We would like to point out to the committee reviewing this that cardiac rehabilitation has been considered both by the American Medical Association and the American Heart Association by a special committee set up in April 1981 as a therapeutic modality when exercise is utilized in conjunction with medical and surgical intervention. It is, therefore, our contention that the post operative [sic] therapeutic benefits of cardiac rehabilitation are clearly understood by the American Medical Association and other interested parties and therefore we would very much wonder whether it is not time to consider reevaluating the current policies of your company.
>
> ". . . Cardiac exercise is not indeed only preventive but it is also now a recognized entity in addition to Inderal, Nitroglycerine and open heart surgery."

In an informal note dated September 8, 1982, the fiscal intermediary advised the beneficiary of the letter received from Dr. and advised him if he wished to appeal further to request a review by OCHAMPUS. By letter dated September 10, 1982, the beneficiary appealed to OCHAMPUS. The letter stated in part:

> ". . . however, the claim of the Administrator that this is a 'general exercise program' is patently untrue. It ignores the fact that the preventive part of my treatment was quadruple coronary artery by-pass surgery, performed in December 1981.

> "After surgery, the cardiologists, and my internist, prescribed rehabilitative therapy treatment to restore cardiac function and vascular efficiency. This was done at Imperial Point Medical Center in , , in a program conducted by , ., M.D. It is a fully-supervised program using telemetry to monitor cardiac function. . . .
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> * * * *
>
> "My cardiac rehabilitation program is no less necessary than the physical rehabilitation therapy required by a stroke victim. It is not preventive in any sense unless it is to prevent my being a cardiac cripple the rest of my life."

The beneficiary included with his correspondence a September 21, 1982, letter addressed to the Director, Contract Management, OCHAMPUS, from , M.D., F.A.C.C., that states:

> "[The beneficiary] has been a patient of mine for more than one year. He has undergone coronary artery by-pass grafting. An important part of the treatment of a cardiac patient is rehabilitation. The cardiac rehabilitation program at Imperial Point Medical Center was a necessary step in the treatment of his disease."

In the First Level Appeal Determination dated November 29, 1982, OCHAMPUS denied coverage. The decision stated:

> "The patient's cardiac rehabilitation program does not fit the definition of physical therapy under CHAMPUS and does not qualify for benefits as physical therapy. Based on similar precedential cases, and on the lack of medical documentation, authoritative medical literature and recognized professional opinion sufficient to establish the general acceptance and efficacy of a cardiac rehabilitation program at the time the care was received, the program the patient undertook is found to be not medically necessary in the treatment of a post cardiac quadruple bypass patient. CHAMPUS excludes all services and supplies related to noncovered treatment, therefore, all services and supplies provided in connection with the cardiac rehabilitation program are not a benefit."

In response to this determination, Dr. wrote to OCHAMPUS by letter dated January 5, 1983, requesting further review. Dr. stated:

> ". . . that following coronary artery bypass, which as you know is a palliative procedure without physical and psychological conditioning, the patient frequently does not recover to a life of full benefit despite the fact that he has new blood flow to his myocardium. It is, therefore, my contention that CHAMPUS has not truly investigated the medical necessity of this program and I would ask that a further medical review be carried out by your organization in order to truly assess whether cardiac rehabilitation is medically necessary following open heart surgery, myocardial infarctions and in any other treatment modality. It is truly an accepted means of treatment for patients who have had open heart surgery, in addition to medications, and as you may or may not be aware as a result of cardiac rehabilitation it has been possible for [the beneficiary] to be weaned off of all his medications despite your feelings that this is not medically necessary . . . . [I]t is also our contention that physical therapy was administered to the patient and while it was not in the form of voodoo, massage, heat, light, water, or other hands on touching with modalities that are of limited benefit, he did receive physical therapy treatment on a daily basis in the form of flexibility and strength training. These physical therapy treatments are truly means of improving one's ability to recover following a cardiac surgical procedure and, therefore, under your regulation 6010.8-R he did receive treatment by physical methods rather than physical agents. Physical therapy does not imply the use of physical agents alone. I am sure that in all the physical therapy departments in this country it is truly evident that both muscular training and flexibility are an important part of the process of treatment and the departments would close if everything they did was to use hydrotherapy, laser beams and other highly sophisticated equipment. [The beneficiary] did receive on a three times a week basis physical therapy treatments by these methods. I, therefore, request that CHAMPUS re-open the investigation of this and that they look into the definition of their own rules and regulations."

Dr. letter was accepted as an appeal under chapter X of the Regulation; the beneficiary also requested a hearing on the First Level Appeal determination.

The record contains a number of references to articles in the Journal of Cardiac Rehabilitation that were either included in the record as exhibits or referred to at the hearing. These are discussed below under issues and findings of fact.

The hearing was held in , , on May 3, 1983, before OCHAMPUS Hearing Officer, Ms. . Both the beneficiary and Dr. attended the hearing; the beneficiary's wife was also present although she did not testify. The Hearing Officer has issued her Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are whether the cardiac rehabilitation program provided the beneficiary was medically necessary and whether the program constituted physical therapy.

Medically Necessary

The CHAMPUS regulation, DoD 6010.8-R, provides in chapter IV, A.1., as follows:

> "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 . . . ."

Interpretation of this Regulation, as it applies to the treatment in dispute, requires a review of what is meant by the term "medically necessary." The definition in DoD 6010.8-R, chapter II, provides:

> "'Medically Necessary' means the level of services and supplies (that is, frequency, extent, and kinds) adequate for the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Medically necessary includes concept of appropriate medical care."

The definition of "appropriate medical care" requires that, ". . . 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."

The Office of Assistant Secretary of Defense (Health Affairs) has in four previous FINAL DECISIONS considered the medical necessity of cardiac rehabilitation exercise programs. In OASD(HA) Case File 01-81, dated May 21, 1982, it was stated:

> "To constitute a CHAMPUS covered service, the cardiac rehabilitation program must therefore be adequate for the diagnosis and treatment of illness or disease and correspondingly constitute treatment of a disease or illness. . . . The acceptance and efficacy of the treatment of post-myocardial infarction by the cardiac rehabilitation program must therefore be documented."

It was concluded in OASD(HA) 01-81 that:

> ". . . the general acceptance and efficacy of the program in the treatment of post-myocardial infarctions is not supported by medical documentation nor recognized professional opinion and authoritative medical literature contemporaneous with the dates of care."

In OASD(HA) 01-81 medical reviews requested by OCHAMPUS from the Colorado Foundation for Medical Care were discussed. In commenting on the medical reports, this Office stated:

> "These reports reveal a change in thinking by the reviewing physicians regarding the medical necessity of the [cardiac rehabilitation] program based on evidence which suggests the programs might contribute to a reduction in death in the first six months following an acute myocardial infarction and the increasing acceptance of the programs by the general medical community. However, the opinions clearly state cardiac rehabilitation programs remain an unproven modality, are not a standard of care in every community, and evidence does not support a reduction of heart disease as a result of the programs. The physicians cite improved function capacity to perform activities of daily living with less fear, earlier return to work, and increased understanding by the patient of the need for management of hypertension and stress as supporting the medical necessity. . . .
>
> * * * *

> "The evidence herein and the peer review opinions given at the time the services were rendered disclose no evidence of the documented effectiveness of the exercise programs in the treatment of myocardial infarction (coronary heart disease); instead the file clearly indicates its unproven nature."

In OASD(HA) Case File 20-79, it was said:

> "Further, it is acknowledged that the program may very well have produced beneficial results for the appealing party -- as would be anticipated for any individual with or without a heart condition, who undertook a program of structured exercise and weight reduction. We do not concur, however, that the exercise/weight reduction regimen constituted specific treatment. Further, the fact that a physician orders, prescribes or recommends that a patient pursue a certain course does not, in itself, make it medically necessary treatment. A physician in caring for his or her patient may, and properly so, advise and recommend in many areas beyond specific treatment. This is particularly true relative to encouraging changes in lifestyles--i.e., increased exercise, elimination of smoking, weight reduction, etc."

This same analysis was followed in OASD(HA) Case File 83-16 and OASD(HA) Case File 83-17.

The record includes a number of references to medical articles, which it is argued provide authoritative medical literature on the efficacy of cardiac rehabilitation programs. For example, the beneficiary submitted, as one of his exhibits, the "Statement On Exercise" by the American Heart Association, which was published in the American Heart Association Rehabilitation News. The "Statement" was approved by the AHA Steering Committee on Medical and Community Programs on May 8, 1981. In discussing morbidity and mortality, it stated:

> "Epidemiological data suggest that men working in physically demanding jobs or performing strenuous recreational activities have less coronary heart disease during middle age. When present, coronary heart disease appears to be less severe and occurs later in life in physically active men than in physically inactive men. Experience in non-randomized trials suggests that medically prescribed and supervised exercise can reduce

> the morbidity and mortality rates of patients with ischemic heart disease; however, to date, a unifactorial randomized control trial has not been reported that provides unequivocal data to confirm whether exercise either prevents or retards the development of coronary heart disease." (emphasis added)

The Steering Committee also stated:

> "Involvement of Medical Professionals. Prior to a substantial increase in physical activity, patients with known or suspected cardiovascular, respiratory, metabolic, orthopedic, or neurologic disorders should obtain advice from their personal physician regarding exercise plans. In turn, physicians should have access to appropriate guidance for such patients. Older, sedentary individuals may also wish to seek medical advice. In order to provide such advice, a medical evaluation may be necessary. Exercise testing may be included to provide a basis for an appropriate exercise prescription. In some instances, it is necessary for patients to carry out their exercise prescription in a medically supervised program in an effort to detect exercise induced cardiac abnormalities and to prevent sudden death." (emphasis added)

To say the evidence "suggests" exercise can reduce morbidity is not sufficient medical evidence to document the efficiency of cardiac rehabilitation exercise programs. To describe the need for a medically supervised program as "an effort to detect exercise induced cardiac abnormalities and to prevent sudden death" is a description of preventive care not medical efficacy.

At the hearing, the beneficiary several times referred to the October 1982 issue of the Journal of Cardiac Rehabilitation (JCR) and its articles on "The State of the Art 1983." Review of this issue of JCR reveals that, in general, the articles discussed programs at various clinics and hospitals and did not discuss the effectiveness and the acceptance of cardiac rehabilitation programs; however, it is worth noting comments from several of the articles. For example, the description of the cardiac rehabilitation program at the University of , states:

> "Because spontaneous improvement in myocardial perfusion and performance occurs in patients during the early recovery period following myocardial infarction or coronary artery bypass surgery and because we are investigating whether or not exercise alters perfusion and function, we do not accept

> patients . . . until four months after their cardiac event, at which time they are stable clinically. However, nonresearch patients are encouraged to begin our program as soon as two weeks after discharge from the hospital."

The article entitled, "Proceedings of the Cardiac Rehabilitation Workshop Conference, April 24-25, 1980" stated:

> "The performance workshop participants discovered that there is more not known about cardiac rehabilitation than there is known. Many things we are doing are relative to our own desires and styles. Although our methods may be theoretically rational, they have not been scientifically proved. One consensus reached was that even though concepts of cardiac rehabilitation have been progressing rapidly, they are still in the formative stage."

Another article "In the Literature" reviewed an article entitled "In-Hospital Exercise After Myocardial Infarction Does Not Improve Treadmill Performance" that appeared in the New England Journal of Medicine in 1981. The summary stated:

> "Prolonged bed rest after myocardial infarction is thought to result in deconditionings, manifested by increased heart-rate and blood-pressure responses to exercise and decreased functional capacity. We studied the effects of early, supervised exercises in preventing deconditioning after acute myocardial infarction . . . we were unable to demonstrate any significant beneficial or deleterious effects of an early in-hospital exercise program."

The Hearing Officer in her Recommended Decision felt the status of medical documentation was accurately summarized in an article entitled "Influence of Duration of Cardiac Rehabilitation on Myocardial Infarction Patients," Journal of Cardiac Rehabilitation 2(3) 243-246, 1982. The Hearing Officer quotes the authors as stating:

> "Rehabilitation of cardiac patients after myocardial infarction has the following aims: (1) reduction in morbidity and mortality and (2) improvement in psychological, social, and work status of the patient. To date, however, it has not been clearly demonstrated that cardiac rehabilitation reduces mortality and morbidity. Although some published reports suggest that cardiac rehabilitation

> does reduce mortality and morbidity, either they do not have randomized control groups or they have a low number of patients. Randomized studies have not shown any significant differences between rehabilitated patients and controls. However, improvement in physical work capacity (PWC) and an earlier return to work have been demonstrated."

Also included in the record is a July 1981 article from the American Journal of Cardiology entitled "Effects of a Prescribed Supervised Exercise Program on Mortality and Cardiovascular Morbidity in Patients after a Myocardial Infarction." The authors stated:

> "The results of this study suggest that a program of prescribed supervised physical activity for patients after myocardial infarction may be beneficial in reducing subsequent cardiac mortality, but the evidence is not convincing."

The authors went on to conclude that the implications of the study were, "The case for exercise in persons with known myocardial infarction is neither proved nor disproved."

The file includes a copy of the Directory of Cardiac Rehabilitation Units - 1981 by the American Heart Association. The Directory lists over 700 cardiac rehabilitation units. Providers are listed for every state, the , and . The list includes Veterans Administration Hospitals and military treatment facilities. The Directory establishes that cardiac exercise programs are readily available and their use is widespread throughout the United States. In addition, there is some evidence, due to the number of hospitals that have cardiac rehabilitation programs, that the program is accepted by the medical profession; however, a directory is not medical evidence that establishes the efficacy of cardiac rehabilitation programs.

The evidence in the record supports the determination previously made in OASD(HA) 01-81, that:

> "[There is an] increasing acceptance of the programs by the general medical community. However, the opinions clearly state cardiac rehabilitation programs remain an unproven modality, are not a standard of care in every community, and evidence does not support a reduction in heart disease as a result of the program."

Dr. , a board certified cardiovascular surgeon and Director of a Cardiac Rehabilitation program, testified at the hearing as an expert witness. His testimony was articulate and knowledgeable. His professional opinion was that cardiac rehabilitation programs were effective in treating heart disease; however, he did not quote any National Association, such as the American Heart Association or American Medical Association Policy Committee, or any scientific study that suppports this position.

The program is popular, the many medical professionals involved in cardiac rehabilitation programs believe in it, and the participants believe the program is effective; yet, there is no scientific evidence to confirm these opinions. As noted by the Hearing Officer, the beneficiary has the burden of proving the position of OCHAMPUS is in error. She further notes that nothing in the record can directly show that the medical necessity and efficacy of cardiac rehabilitation is documented. I agree.

The program followed by the beneficiary in this appeal was from February 10, 1982 to March 5, 1982. The evidence submitted in the record supports the prior decisions by this Office and supports the conclusion that at the time the program was undergone it was not medically necessary as defined in the CHAMPUS regulation. Therefore, I must conclude the beneficiary's cardiac rehabilitation program was not medically necessary and is excluded from CHAMPUS coverage as previously determined in prior decisions.

Physical Therapy

A determination that the program was not medically necessary prevents CHAMPUS coverage. However, both the beneficiary and Dr. described the program as physical therapy. Therefore, it is appropriate to address the issue of physical therapy.

Under DoD 6010.8-R, chapter IV, C.3.j., physical therapy is a CHAMPUS benefit when provided by an authorized physical therapist. The Regulation provides:

> "To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, the beneficiary patient must be referred by a physician and the physical therapy rendered under the supervision of a physician.
>
> * * * *
>
> "(2) General exercise programs are not covered even if recommended by a physician. Passive exercises and/or range of motion exercises are not covered except when prescribed by a physician as an integral part of a comprehensive program of physical therapy."

Under chapter II, B.134, a "physical therapist" means:

> ". . . a person who is specially trained in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods, such as heat, massage, manipulation, therapeutic exercise, hydrotherapy and various forms of energy such as etectrotherapy [sic] and ultrasound), who has been legally authorized (that is, registered) to administer treatments prescribed by a physician and who is legally entitled to use the designation 'Registered Physical Therapist.'"

The record reflects that the exercise program was conducted and monitored by a cardiologist and cardiac nurses and that a physical therapist was present. Dr. testimony at the hearing also established that a physical therapist was present during the program. However, the finding by the Hearing Officer that the program is not physical therapy is supported by the record. The record does not establish that the treatment received was of the type that is considered physical therapy under the CHAMPUS regulation; i.e., the treatment of disease by physical agents and methods. In addition, the CHAMPUS regulation dealing with physical therapy specifically excludes an exercise program.

Secondary Issues

Educational Training

The Regulation at chapter IV, G.44., excludes:

> "Educational services and supplies, training, nonmedical self-care/self-help training and any related diagnostic testing or supplies."

The program was described by Dr. as including nutrition/dietary counseling and stress management. Both Dr. and the beneficiary testified the beneficiary reduced his weight from 179 pounds to 164 pounds. One of the purposes of exercising was to control weight. A major goal of the program was life-style modification. These are all admirable, desirable and, most likely, beneficial goals. They are also achievements that would generally benefit any individual, not just a person with heart disease. The beneficiary's wife was included in some of these educational sessions. These activities, which could possibly account for the claimed success of the program, are specifically excluded from coverage by the above quoted Regulation.

Preventive Care

Dr. emphasized in his testimony that the beneficiary's illness was not bypass surgery but coronary heart disease. Apparently, the beneficiary had a myocardial infarction 20 years earlier but had not suffered one since that time. The bypass surgery, Dr. testified, relieved the beneficiary's symptoms.

Dr. in one of his letters wrote that "cardiac exercise is not indeed only preventive . . . ." The "Statement On Exercise" states, "In some instances, it is necessary for patients to carry out their exercise prescription in a medically supervised program in an effort to detect exercise induced cardiac abnormalities and to prevent sudden death." It is concluded, therefore, that prevention of a future myocardial infarction was a goal of the program. Coverage of such a program is excluded under the specific exclusion of preventive care and routine screening in the CHAMPUS regulation, DoD 6010.8-R, chapter IV, G.38.

Related Charges

"All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment" are excluded from CHAMPUS cost-sharing by DoD 6010.8-R, chapter IV, G.66. Therefore, the monitoring that was performed as a part of the cardiac rehabilitation program is excluded from CHAMPUS cost-sharing. In addition, any diagnostic tests and treatment procedures consisting of stress tests, pulmonary function tests, and electrocardiography function tests which are directly related to the cardiac rehabilitation program are excluded from CHAMPUS coverage.

Hearing Officer's Additional Recommendations

The Hearing Officer after concluding that CHAMPUS cost-sharing was correctly denied made the following comment:

> ". . . but would like to recommend reconsideration. What is appropriate medical care or the generally acceptable norm must change as new programs and treatments prove their effectiveness. Although no authoritative medical articles were presented as part of the record, I also do not believe the medical article which was attached to the OCHAMPUS Statement of Position disproves the medical necessity of these programs . . . . While cardiac rehabilitation does concern itself to a great extent with improving the patient's quality of life, this appears also to be true of other types of medical care. Based upon these factors, I would recommend a reconsideration of denial of benefits for cardiac rehabilitation."

What is not readily apparent from the appeal process is that OCHAMPUS, on the policy level, is constantly reviewing medical treatment programs. In 1982, OCHAMPUS reviewed, at the policy level, cardiac rehabilitation programs. The results were essentially the same as the Hearing Officer's findings. The programs may have some merit, but further study is needed and there is no conclusive evidence that cardiac exercise programs will improve survival. A review of a number of third party payers showed mixed results -- some paid limited cardiac rehabilitation benefits, others did not cover it at all. The uniformed services were polled and appear to endorse the program; however, only a limited number of military treatment facilities have structured or semi-structured cardiac rehabilitation programs.

The policy review did not establish that cardiac rehabilitation programs are effective. To cover the program would require an amendment to current law and regulatory authority, as current benefits are limited to medical necessity. A further troublesome aspect of the programs is they are not limited to exercise but include diet counseling, stress management, life-style changes, counseling with spouses, stop smoking classes, and similar facets. Such items, no matter how effective, are generally excluded from cost-sharing by the Regulation.

I agree with the Hearing Officer that what is considered appropriate medical care may change as new programs and treatments prove their effectiveness. Cardiac rehabilitation programs, however, have yet to be proven to be effective. If the effectiveness of the program ever is established, the components will be evaluated to determine which are considered medical treatment appropriate for CHAMPUS coverage.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the cardiac rehabilitation program undergone by the beneficiary from February 10, 1982, to March 5, 1982, was not medically necessary. I further find the program does not meet the definition of physical therapy set forth in DoD 6010.8-R and CHAMPUS coverage of "therapy" cannot be authorized unless the general acceptance and efficacy at the time of care is established. Claims for participation in a cardiac rehabilitation program from February 10, 1982, to March 5, 1982, including related services and supplies and the appeals of the beneficiary and the provider are 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