DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

AURORA COLORADO 80045

JAN 23 1985

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) FILE 84-11
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-11. It is issued pursuant to the authority of 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the estate of the beneficiary, the deceased son of a retired enlisted man of the United States Army. The beneficiary's estate is represented in the appeal by the deceased beneficiary's father.

The appeal involves the denial of CHAMPUS cost-sharing of claims for 24-hours-per-day private duty nursing services provided to the beneficiary in his home from February 22 to April 11, 1982, and from April 26 to May 5, 1982. The record in this appeal is incomplete with respect to all of the claims submitted to CHAMPUS for the care in dispute; however, information provided by the beneficiary's other insurance indicates that $16,608.00 was billed to them for home care services provided to the beneficiary in 1982. Of this amount, the other insurance paid $8,296.00 leaving the unpaid balance of $8,312.00 as the amount in dispute in this appeal.

The hearing file of record, 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 OCHAMPUS First Level Review determination be reversed and that 3 hours per day private duty nursing services be cost-shared under CHAMPUS. The Hearing Officer's recommendation is based upon a finding that private duty nursing care provided to the beneficiary during the period in question was not custodial care as defined in the Regulation which governs CHAMPUS.

The Director, OCHAMPUS, nonconcurs with the Hearing Officer's Recommended Decision and recommends that the finding of the OCHAMPUS First Level Review determination be upheld. The Director bases his recommendation upon a conclusion the Hearing Officer's interpretation of the CHAMPUS definition of custodial

care is erroneous and would result in an arbitrary and unworkable standard for the processing of custodial care claims and the resolution of custodial care appeals.

Under Department of Defense Regulation 6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject the Hearing Officer's Recommended Decision. In the case of rejection, a FINAL DECISION may be issued by the Assistant Secretary of Defense (Health Affairs) based on the appeal record. The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, accepts the recommendation of the Director, OCHAMPUS, and rejects the Hearing Officer's Recommended Decision. The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to affirm the OCHAMPUS First Level Review determination and deny all but 1 hour per day of the private duty nursing services provided to the beneficiary from February 22 to April 11, 1982, and from April 26 to May 5, 1982, on the basis that the care provided was custodial care. This FINAL DECISION is based upon the appeal record as stated above.

FACTUAL BACKGROUND

The beneficiary was the 20-year-old son of a retired enlisted member of the United States Army. He had a diagnosis of recurrent malignant melanoma with metastasis to the brain and spinal cord. There were also multiple related medical problems, including recurrent aspiration pneumonia, progressive weakness that resulted in paralysis, quadraplegia, and multiple decubitus ulcers. This illness is reported to have commenced in 1976. In September 1981, he was hospitalized and found to have a metastatic tumor to the left side of the upper portion of the spinal cord. This was treated with radiation.

Following the September 1981 hospitalization, the patient received a tracheostomy. At that time, a CT scan showed metastasis to the left posterior portion of the brain. The attending physician ordered 24-hours-per-day private duty nursing care in the patient's home. This care was provided from February 22 to April 11, 1982, and from April 26 through May 5, 1982. The patient was hospitalized from April 11 to April 26, 1982, and again on May 5, 1982 until his death on May 9, 1982.

The attending physician stated that skilled nursing care at home was required to monitor the beneficiary's vital signs, check for neurologic abnormalities, provide tracheostomy care in the form of frequent sunctioning as well as inflating the balloon when the patient ate, and care for the decubitus ulcers. The nurses also supervised and administered medications and were responsible for changing the patient's position.

CHAMPUS claims for the home nursing services provided to the beneficiary were filed with the appropriate fiscal intermediary. Although the record is not complete with respect to the specific history of each claim, it does show that three CHAMPUS claims

totaling $5,400.00 were partially disallowed when the fiscal intermediary's professional medical review determined that the skilled nursing services were custodial care and not a CHAMPUS benefit. The fiscal intermediary continued to deny CHAMPUS cost-sharing of the claims during the appeal process because the nursing services were found to be custodial care. The fiscal intermediary's appeal decision also indicated that two additional CHAMPUS claims for nursing services, one for $2,136.00 and one for $2,492.00, were being denied for the same reason.

On August 6, 1982, the sponsor requested a review of this case by OCHAMPUS. In that letter, the sponsor contended that "the type and extent of special nursing care provided was necessary . . ." and that this type of special nursing service was requested by the attending physician. The sponsor stated that the "primary need for private (special) nursing care was to maintain the tracheostomy in the patient's neck, suctioning often to prevent suffocation and/or pneumonia, and to know when a doctor is needed." The sponsor concluded that any "services which provided and/or supported these essentials of daily living, or acting as a companion or sitter were incidental."

The case was submitted to the Colorado Foundation for Medical Care to obtain a medical review of the nursing services provided to the patient. The medical reviewers, specialists in internal medicine, opined that all of the nursing care described by the attending physician was medically necessary. These services included checking the patient's vital signs, checking for neurological abnormalities, providing tracheostomy care in the form of sunctioning and inflating the balloon to allow the patient to ingest food, changing the position of the patient because of the decubitus ulcers, and checking and administering medications including Decadron, Tagamet, Riopan, Activan, and Keflex. The medical reviewers, however, also opined that only 2 or 3 hours per day were actually involved in providing medically necessary skilled nursing services. The medical reviewers opined that an average adult with minimal instruction could have rendered most of the remaining services provided to the patient. The OCHAMPUS Medical Director also reviewed the record and concurred with the medical review opinions.

The OCHAMPUS Formal Review Decision dated July 1, 1983, upheld the fiscal intermediary's decision finding that the home care provided to the patient from February 22 to April 11, 1982, and from April 26 to May 5, 1982, was custodial. However, CHAMPUS cost-sharing for 1 hour of skilled nursing services per day during these periods was approved under the limited benefits authorized in custodial care cases.

A hearing was requested in a letter dated July 8, 1983, which stated that the primary purpose of the care provided to the patient "was to provide skilled nursing services around the clock." A hearing was held on September 22, 1983.

At the hearing the sponsor testified that in 1981 the beneficiary's physicians determined that it was feasible to give him an overdose of radiation because the results of an overdose are not normally experienced until after 6 months, and the beneficiary's life expectancy was less than 6 months. He also testified that the beneficiary required strict sanitation policies to protect him from disease because of the tracheostomy. He stated that the maintenance of the tracheostomy was the major reason for the home nursing care. He also testified that the beneficiary required assistance to support the essentials of daily living, that the beneficiary's active and specific medical treatment would not reduce the disability to the extent necessary to enable him to function outside of the monitored, controlled and protected environment, and that the beneficiary's continued survival depended upon the nursing services provided to him. He stated that the portion of care which provided assistance to support the essentials of daily living was incidental to the primary purpose for private duty nursing; i.e, care for the tracheostomy, to take and record vital signs, and provide informed reports to the beneficiary's attending physician.

One of the major contentions raised by the sponsor at the hearing concerns the CHAMPUS definition of custodial care. He made specific reference to the regulation provision which indicates that custodial care is that care which is rendered to a patient who has a disability which is "expected to continue and be prolonged." He stated that in his opinion this portion of the custodial care definition was not applicable because the beneficiary had such a short life expectancy.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether the private duty nursing services provided to the beneficiary at home from February 22 to April 11, 1982, and from April 26 to May 5, 1982, were custodial care and thus excluded from cost-sharing under the CHAMPUS Basic Program. If this primary issue is answered in the affirmative, then any secondary issues concerning the medical necessity, appropriateness, and level of the nursing care provided are rendered moot to the extent that the services exceeded the maximum allowable benefit of 1 hour per day of private duty nursing care under the CHAMPUS custodial care provision.

Custodial Care

Custodial care is specifically excluded as a benefit of the CHAMPUS Basic Program under the provisions of Title 10, United States Code, section 1077(b)(1). This specific statutory exclusion finds implementation in Department of Defense Regulation DoD 6010.8-R, which governs CHAMPUS. Custodial care is defined in DoD 6010.8-R, chapter II, B.47., as:

> "That care rendered to a patient (a) who is mentally or physically disabled and such

> disability is expected to continue and be prolonged, and (b) requires a protected, monitored, and/or controlled environment whether in an institution or in the home, and (c) who requires assistance to support the essentials of daily living, and (d) who is not under active and specific medical, surgical, and/or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, and/or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising and/or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, and/or provide for the patient's comfort, and/or assure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N. or L.P.N."

A note which follows this definition provides as follows:

> "The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under the CHAMPUS Basic Program."

It is clear from the foregoing definition that the determination of custodial care is not based upon a question of medical necessity for the kind or level of treatment being provided to the beneficiary. A determination of custodial care derives from the basic condition of the patient, the kind and purpose of the care being provided, and the patient's prognosis. If the patient's condition and prognosis are such that they meet the criteria established by the custodial care provision, then, irrespective of the medical necessity of the treatment being provided, it is not a benefit of CHAMPUS.

Chapter II, B.67., DoD 6010.8-R, also defines the "essentials of daily living" as:

> ". . . care which consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and general monitoring, bowel training and or management; safety precautions; generally preventive procedures (such as turning to prevent bed sores);

> passive exercise; companionship; recreation; transportation; and such other elements of personal care which can reasonably be performed by an untrained adult with minimal instruction and/or supervision."

The specific exclusion of custodial care in the CHAMPUS regulation is found in chapter IV, paragraph E.12. That provision includes the definition of custodial care cited above and acknowledges that this is a very difficult area to administer. It is also noted therein that many beneficiaries (and sponsors) misunderstand what is meant by custodial care, assuming that because custodial care is not covered it implies that custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended. The Regulation also cites specific kinds of conditions that can result in custodial care. It provides as follows:

> "There is no absolute rule that can be applied. With most conditions there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases might be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages or pre-senile and senile dementia. These conditions do not necessarily result in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself [i.e., the beneficiary's current physical disability] that is controlling but whether the care being rendered falls within the definition of custodial care [i.e., whether the care is likely to improve the disability]." (Paragraph E.12.b., chapter IV, DoD 6010.8-R)

The Regulation also recognizes that even though a case may be determined to be custodial in nature, there are certain benefits which continue to be available in connection with such cases. These include prescription drugs and limited nursing services. With respect to the provision of limited nursing services, the Regulation provides:

> "It is recognized that even though the care being received is determined to be primarily custodial, an occasional specific skilled nursing service may be required. Where it is determined such skilled nursing services are needed, benefits may be extended for one (1) hour of nursing care per day." (Paragraph E.12.C.(2), chapter IV, DoD 6010.8-R)

Thus, the Regulation places an absolute limit on the amount of skilled nursing care available once a determination of custodial care is made.

The evidence of record clearly establishes that the beneficiary was diagnosed as suffering from terminal cancer. It is also clear that his disease had progressed to the point that he was severly disabled; that he required a protected, monitored, controlled environment; that he required assistance to support the essentials of daily living; and that there was no medical, surgical, or other treatment available which had any hope of reducing the beneficiary's disabilities to enable him to function outside of the protected, monitored, and controlled environment.

As stated above, the sponsor argued that dispite these facts the CHAMPUS custodial care exclusion should not be applied to this case. His rationale for this position is that while his son's condition met most of the CHAMPUS criteria for custodial care, his condition was not expected to be prolonged because the beneficiary had only a few weeks to live.

The Hearing Officer accepted the sponsor's position. His rationale is stated, in part, as follows:

> "This Hearing Officer is satisfied that many of the elements of custodial care are satisfied by the facts in this . . . case. The subsidiary element of custodial care remaining as an issue for decision by this Hearing Officer is whether the Beneficiary's disability in this case was' expected to continue and be prolonged' as that term is used in the regulations. On the one hand, it is clear that it was 'expected to continue.' Thus the remaining issue for determination is whether it was expected to 'be prolonged' as that term is used in the regulation.
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> "In [this] case, the private duty nursing services were provided for a period of approximately eight weeks out of a nine week period, punctuated by a readmission to the hospital after approximately seven weeks and terminated by a readmission to the hospital culminating in death after the total period of approximately nine weeks.
>
> "In attempting to determine whether such confinement for the period of nine weeks is 'prolonged' as used in the regulations, the [other] ASD(HA) decisions [considered by the Hearing Officer] do not provide conclusive precedential value, since the time periods involved in [them] were significantly greater. [The sponsor] suggests that a

> dictionary definition of 'prolonged' supports his contentions. His proffered definition is that prolong means '(1) to length [sic] in time, continue, (2) to lengthen in extent, scope or range . . .'
>
> "The evidence indicates that [the beneficiary's] condition was expected to continue and that he was not expected to live for long: one physician suggested to [the sponsor] that his son had less than six months to live, this occurring approximately four and one-half months prior to his son's death. Without any other Interpretations, precedents or other authorities, this Hearing Officer is of the opinion that common usage should be applied to determining the meaning of 'prolonged.' It is not felt that this term as generally used by persons in discussing lengthy illnesses would be applied to a confinement of eight or nine weeks. 'Prolonged' means 'lengthened' or 'extended.' Such a confinement would not be an 'extended' confinement in general usage. Such a confinement is not comparable to the confinements illustrated in the two cases set forth by OCHAMPUS as precedents.
>
> "It is, therefore, the conclusion of this Hearing Officer that OCHAMPUS prevails on each and every element of the definition of 'custodial care' except that element requiring that the patient's condition be expected to be prolonged. As to this particular element, the customary usage of the word would appear to apply to a different sort of case than is presented in [this] case, and in the absence of any clear authority to the contrary it is concluded that the [beneficiary's] condition was not 'prolonged.' It was not, therefore, 'custodial care' as defined in the regulations for which benefits would be excluded."

I have very carefully considered the arguments presented by the sponsor and the rationale of the Hearing Officer on this issue. I find that the interpretation adopted by the Hearing Officer of the requirement that a disabling condition be expected to continue and be prolonged is erroneous. In making his recommendation on this element, the Hearing Officer concluded that the words "continued" and "prolonged" as used in the Regulation should be given two meanings establishing two separate requirements or standards in the evaluation of a custodial care case. Applying these meanings, the Hearing Officer found that

while the beneficiary's condition was expected to continue in the sense that there was little or no likelihood of a significant remission or improvement, it was not expected to be prolonged because of the beneficiary's anticipated short life expectancy. The evidence indicates that the beneficiary's life expectancy was less than 6 months at the time the private duty nursing services at issue were initiated.

Certainly, I can agree with the Hearing Officer that this is a relatively short period and does not suggest the concept of a prolonged life. However, the regulation criterion under consideration here does not relate to life expectancy, but, rather to the duration of a disability. In this context, I find that the standard which must be applied relates to the duration of the disability within the context of the particular case. That is, it must be determined whether the disability is likely to exist over a substantial portion of the duration of the beneficiary's illness, irrespective of how long that may be. To find otherwise and accept the Hearing Officer's recommendation on this issue would place CHAMPUS in the impossible position of attempting to administer the custodial care exclusion based upon estimates of life expectancy. Surely, if this interpretation were adopted, there would be cases in which benefits would be erroneously cost-shared when an anticipated short life span turned out to be "prolonged." Conversely, there would no doubt also be cases in which an anticipated "prolonged" life span would result in the denial of cost-sharing of care for a beneficiary who unexpectedly suffered an early death. Such a rule, tied to estimates of anticipated life expectancy as proposed by the Hearing Officer, would be virtually impossible to administer. Because of the results it would necessarily produce, I also believe such a rule, tied to life expectancy alone, to be arbitrary and without a rational basis. Therefore, for the reasons stated above, I have rejected the Hearing Officer's recommendation on this issue.

I find that the beneficiary's disability was expected to continue and be prolonged within the context of his individual case. I further find that the beneficiary's case met all of the other criteria for a custodial care case under CHAMPUS and that his care was properly classified by the fiscal intermediary and OCHAMPUS as custodial. Therefore, the private duty nursing services provided to the beneficiary at home from February 22 to April 11, 1982, and from April 26 to May 5, 1982, were custodial care. The maximum CHAMPUS benefit for private duty nursing services under these circumstances is 1 hour per day. That amount was previously authorized by the OCHAMPUS Formal Review Decision of July 1, 1983.

The Hearing Officer discussed at some length the collateral issues relating to the medical necessity, appropriateness, and level of the nursing care provided to the beneficiary. However, because of the finding made herein that the care provided to the beneficiary was primarily custodial, any extended discussion of the medical necessity, appropriateness, and level of these

services beyond the previously allowed maximum benefit of 1 hour per day is unnecessary. I concur with the OCHAMPUS Formal Review Decision to allow the maximum available benefit of 1 hour per day of skilled nursing care.

SECONDARY ISSUES

Prescription Drugs

The appealing party has not raised a substantial issue with respect to the payment by CHAMPUS of prescription drugs provided to the beneficiary during the period of his home care at issue in this appeal. Apparently, this derives from the fact that these claims were previously paid by the beneficiary's other insurance. The Hearing Officer considered this issue, however, and recommended a finding that prescription drugs be allowed if claims were submitted. Paragraph E.12.c., chapter IV, DoD 6010.8-R, allows for the payment of otherwise covered prescription drugs in custodial care cases. Consequently, I concur with the Hearing Officer's recommendation on this issue to the extent that such medications are determined to be otherwise covered (i.e. medically necessary and appropriate) and to the extent that their cost has not been covered by other insurance.

Erroneous Payments of CHAMPUS Claims

At the hearing, the sponsor contended that the fiscal intermediary had issued payment for one of the claims at issue in this appeal. He argued that a precedent for payment was established thereby which should be followed in the adjudication of subsequent claims. If such a payment was made and if it exceeded the maximum allowable benefit of 1 hour of skilled nursing care per day as determined herein, then it was an erroneous payment. Such erroneous payments are never given precedential value for the adjudication of subsequent claims. Rather, the Department of Defense is required to correct erroneous expenditures of appropriated funds by recoupment of the monies involved.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the home private duty nursing services provided to the beneficiary from February 22 to April 11, 1982, and from April 26 to May 5, 1982, were custodial care within the meaning of the CHAMPUS regulation, DoD 6010.8-R. As a result, the maximum benefit allowable for these services is 1 hour per day. The beneficiary's CHAMPUS claims for private duty nursing services in excess of 1 hour per day and his appeal are denied. This determination is based upon findings that the beneficiary was severely disabled and that the disability was expected to continue and be prolonged; that the beneficiary required a protected, monitored, and controlled environment either in an institution or in the home; that the beneficiary required assistance to support the essentials of daily living;

and that there was no active and specific treatment available to the beneficiary which would reduce the disability to the extent necessary to enable him to function outside the protected, monitored, and controlled environment. The CHAMPUS claims for these private duty nursing services to the extent that they exceed 1 hour of such services per day are denied. The Director, OCHAMPUS, is instructed to review this case to insure that CHAMPUS payments made on behalf of this beneficiary accurately reflect the maximum benefit of 1 hour of private duty nursing services per day. Appropriate action under the Federal Claims Collection Act should be taken to collet any erroneous payments which may have been made in this case. Issuance of this FINAL DECISION completes the administrative appeal process as provided under DoD 6010.8-R, chapter X, and no further appeal is available.

William Mayer, M.D.

REC DEC
84-11

RECOMMENDED HEARING DECISION

Claim for CHAMPUS Benefits

In the appeal of:

Beneficiary

Sponsor

SS#

This case is before the undersigned Hearing Officer pursuant to the claimant's request for hearing on the First Level Appeal Decision dated July 1, 1983 in which the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) denied the claim and pursuant to which the claimant requested a hearing. This hearing was held pursuant to Regulation DoD 6010.8-R, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Chapter X, Section F, Paragraph 4, and Section H, Paragraph 2b.

The hearing was conducted on Thursday, September 22, 1983, in Atlanta, Georgia. Present at the hearing were the undersigned Hearing Officer and Mr.

ISSUES

The general issue before the Hearing Officer is whether the claimant's request for payment for private duty nursing care in the home for a period of approximately nine weeks for the beneficiary, a terminal cancer patient, is a covered CHAMPUS benefit, or whether it is excluded as custodial care or otherwise fails to qualify for coverage. Those general issues are set forth in certain specific issues considered at the hearing as follows:

(1) Were the private duty nursing services provided to the patient in the home from February 22 to April 11, 1982, and from April 26 to May 5, 1982, medically necessary in the treatment of disease or illness, and, if so, was such care custodial care and therefore excluded from coverage under the CHAMPUS Basic Program?

(2) Whether the home private duty nursing care was intensified, skilled nursing care which required the technical proficiency and scientific skills of a Registered Nurse as required by DoD 6010.8-R, Chapter IV, C.3.o.?

APPLICABLE REGULATIONS

The regulations applicable to the resolution of this matter are those found in the DoD Regulations, 6010.8-R adopted in 1977 and listed as follows:

Chapter IV, A.1. - Scope of Benefits

Chapter II, B.14. - Appropriate Medical Care

Chapter II, B.47. - Custodial Care

Chapter II, B.104. - Medically Necessary

Chapter II, B.142. - Private Duty (Special) Nursing Services

Chapter II, B.161. - Skilled Nursing Service

Chapter IV, C.3.o. - Private Duty (Special) Nursing

Chapter IV, E.12.c. - Custodial Care

Chapter IV, G.7. - Exclusions and Limitations: Custodial Care

Those regulations provide the following:

Chapter IV, subsection A.1., provides for medically necessary services and supplies required in the diagnosis and treatment of illness or injury.

Chapter II, subsection B.14., defines "appropriate medical care," in part, as 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 and specifies that the medical environment in which the medical services are performed must be at the level adequate to provide the required medical care.

Chapter II, subsection B.47., defines "custodial care" as "that care rendered to a patient (a) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (b) who requires a protected, monitored and/or controlled environment whether in an institution or in the home, and (c) who requires assistance to support the essentials of daily living, and (d) who is not under active and specific medical, surgical and/or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, and/or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising and/or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, and/or provide for the patient's comfort, and/or assure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a R.N. or L.P.N."

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under the CHAMPUS Basic Program.

Chapter II, subsection B.67., defines the "essentials of daily living" as ". . . care which consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and general monitoring, bowel training and/or management; safety precautions; general preventive procedures (such as turning to prevent bed sores); passive exercise; companionship; recreation; transportation; and such other elements of personal care which can reasonably be performed by an untrained adult with minimal instruction and/or supervision."

Chapter II, subsection B.142., defines "private duty (special) nursing services" as "skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing Registered Nurse (RN) or licensed Practical or Vocational Nurse (LPN or PVN), only when the medical condition of the patient requires intensified skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician."

Chapter II, subsection B.161., defines skilled nursing services as a service which can only be furnished by an R.N. (or L.P.N. or L.V.N.) and required to be performed under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheostomy aspiration and insertions. Skilled nursing services are other than those services which primarily provide support for the essentials of daily living or which could be performed by an untrained adult with minimum instruction and/or supervision.

Chapter IV, paragraph C.3.o., provides benefits for skilled nursing services rendered by a private duty (special) nurse to an individual requiring intensified skilled nursing care which can only be provided with the technical proficiency and scientific skills of an R.N. Where the services of a registered nurse (R.N.) are not available, benefits may be extended for the services of a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.). Among the requirements, in part are:

> (1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital which does not have an intensive care unit (ICU).

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) (Omitted as not applicable.)

(4) Private duty (special) nursing care does not, except incidentally, include services which primarily provide and/or support the essentials of daily living, or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those which could be rendered by the average adult with minimal instruction and/or supervision, the services would not qualify as covered private duty (special) nursing services regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing services or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care should be submitted at least every thirty (30) days. (i.e., monthly). Each claim will be reviewed and the nursing care evaluated as to whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available for only a portion of the care, i.e., providing benefits only for that time actually required to perform medically necessary skilled nursing services. In the event that full time private duty (special) nursing services are engaged, usually for convenience and/or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than one (1) hour of nursing care payable in any twenty-four (24) hour period during which skilled nursing services are determined to have been rendered. Such situations are often better accommodated through the use of visiting nurses. This allows the personal services, which are not coverable by CHAMPUS, to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

Chapter IV, subsection E.12.c., provides for certain limited custodial care benefits as follows:

> (1) "Prescription Drugs. Benefits are payable for otherwise covered prescription drugs, even if prescribed primarily for the purpose of making the person receiving custodial care manageable in the custodial environment."
>
> (2) "Nursing Services: Limited. It is recognized that even though the care being received is determined to be primarily custodial, an occasional specific skilled nursing service may be required. Where it is determined such skilled nursing services are needed, benefits may be extended for one (1) hour of nursing care per day."

Chapter IV, subsection G.7., excludes custodial care "regardless of where rendered except as otherwise specifically provided in paragraph E.12.e. of this Chapter IV."

EVIDENCE CONSIDERED

The decision herein is based on the record in this file as the same exists as of the closing of the record on October 3, 1983, including the official file of documents duly transmitted to the Hearing Officer and the claimant prior to the hearing, con-

sisting of Exhibits 1 through 25 and an Index of those Exhibits, as well as the testimony and certain exhibits added to this case record at the hearing, those being Exhibits 26, the Notice of Hearing; Exhibit 27, the Statement of OCHAMPUS Position, dated 9-13-83; Exhibit 28, Memorandum re: conference with Medical Director, dated 9-13-83; Exhibit 29, Photocopies of Final Decisions in ASD(HA) Case Files 06-80 and 82-05; Exhibit 30, Written Statement by Mr. .. Exhibit 31, Letter Report from Mohammad Al-Mulki, M.D., dated 9-16-83; Exhibit 32, List of Claim Numbers as submitted by . Exhibit 33, Comments of . in response to Statement of OCHAMPUS Position, superimposed over photocopy of Statement; Exhibit 34, Photocopy of Card evidencing receipt of Claim No. 2140-04134-01; plus certain exhibits added to the case record after the hearing including Exhibit 35, Letter from Home Care America, dated 9-28-83; and Exhibit 36, Written Comments by on the ASD(HA) Decisions, dated 9-29-83.

SUMMARY OF EVIDENCE

the deceased son of the claimant, was hospitalized in September 1981 for a condition diagnosed as a metastatic tumor to the left side of the upper portion of the spinal cord. He had suffered since 1976 from medical problems associated with a diagnosis of malignant melanoma which progressed by 1981 to metastasis to the brain and spinal cord, as well as recurrent aspiration pneumonia, progressive weakness resulting in paralysis quadraplegia and multiple decubitus ulcers.

Following the September 1981 hospitalization, the patient received a tracheostomy and a CT scan showed metastasis to the left posterior portion of the brain. The attending physician ordered twenty-four hour per day skilled nursing care in the patient's home between the dates at issue in this case. The claimant obtained such services. The patient was taken back to the hospital on May 5, 1981 and remained there until his death on May 9, 1981.

After insurance claims, charges for the balance were filed with OCHAMPUS, the fiscal intermediary disallowed these claims on April 22, April 27, and May 5, 1982 on the grounds that they involved custodial care. The total amount in controversy appears to be $8,311 by OCHAMPUS calculation.

The fiscal intermediary conducted an Informal Review resulting in a decision on June 10, 1982 and an Automatic Reconsideration Decision on June 24, 1982, still finding the denial of benefits appropriate on the grounds that the services were custodial care. A First Level Appeal was requested and conducted by OCHAMPUS based in part on a peer review study by the Colorado Foundation for Medical Care.

The Formal Review Decision dated July 1, 1983 modified the previous denial of the claims to the extent of allowing the maximum one hour of skilled nursing service per day authorized pursuant to DoD 6010.8-R, CHAPTER IV.e.12.c., which provides for certain benefits, including prescription drugs and limited nursing services even where care is custodial in nature.

Following this adverse ruling in the First Level Review, a hearing was requested. The case was referred to this Hearing Officer on August 26, 1983 and heard on September 22, 1983 as previously scheduled.

The beneficiary was a twenty year old male with a diagnosis of recurrent malignant melanoma, metastasis to the brain and spinal cord and multiple related medical problems, including recurrent aspiration pneumonia, progressive weakness that resulted in paralysis quadriplegia and multiple decubitus ulcers. He had suffered from the malignancy for approximately five years prior to his hospitalization in September, 1981 when he was found to have a metastatic tumor to the left side of the upper portion of the spinal cord for which he received radiation treatments. A CT scan show metastatis to the left posterior portion of his brain.

He was considered to be a terminal cancer patient. Because of the problems with aspiration pneumonia, a tracheostomy was performed. This required frequent aspiration and suction procedures. In February, 1982 he was allowed to go home as a result of his expressing a desire to do so. The private duty nursing care was ordered and certified to be medically necessary by the attending physician.

The nursing services were provided by both Registered Nurses and Licensed Practical Nurses sent by the agency, Home Care America. The services were provided on a basis of twenty-four hours per day from February 22 through April 11, 1982. On April 11, 1982, the beneficiary was returned to the hospital for further radiation therapy. The beneficiary was returned to the same level of home

care on April 26. His condition was not altered significantly until May 1982 when he became quadriplegic. He was readmitted to the hospital on May 5, 1982, where he remained until his death on May 9, 1982.

The record is not entirely clear as to the details insofar as the number and amounts of the claims submitted, for reasons explained in the Statement of OCHAMPUS Position reciting inability to obtain some claim information from a predecessor Fiscal Intermediary. By OCHAMPUS calculations, the amount in dispute in the case is $8,311 and according to records, this represents nine claims.

The attending physician, Dr. Kashlan, stated that skilled nursing care in the patient's home was required to minitor his vital signs, check any neurologic abnormalities, provide tracheostomy care in the form of frequent suctioning and inflating the balloon when the patient ate, care for the decubitus ulcers, changing the patient's position and supervising and administering medications. In addition, Dr. Mohammad Al-Mulki, who saw the beneficiary in January 1982 at the request of Dr. Kashlan, stated that the beneficiary's condition was weak and he required a tracheostomy for intensive airway hygiene.

As part of its review of the case, OCHAMPUS submitted the case to the Colorado Foundation for Medical Care for a medical opinion as to the medical necessity of the nursing services provided to the beneficiary, asking also for a determination of what portion of a twenty-four hour period was spent by the private duty nurses

providing medically necessary skilled nursing services. The peer review physicians were not asked, and did not offer, to render an opinion as to whether the care was custodial.

The peer review was handled by two specialists in internal medicine; the peer review opinion was to the effect that the nursing care was medically necessary, because "his continued survival depended on it." The peer review physicians concluded that the tracheostomy care was a skilled nursing service but that an average adult with minimal instructions could have rendered most of the services provided to the beneficiary. The peer review physicians concluded based on their review of the record in the case that "about 2-3 hours per day were involved in providing medically necessary skilled nursing services."

The testimony of [redacted] contained substantially the following: That a visit to Dr. Saiba in December 1981 resulted in a determination that it was feasible to give the beneficiary an overdose of radiation because the results of an overdose are not normally experienced until six months, and the beneficiary's life expectancy was less than six months; that the beneficiary required strict sanitation policies to protect him from disease because of the tracheostomy; that to suction and maintain the trach was among the major reason for nursing care; that the beneficiary did require assistance to support the essentials of daily living; that the beneficiary's active and specific medical treatment would not reduce the disability to the extent necessary to enable him to function normally; that the beneficiary's continued survival

continued on the nursing services provided in this case; that the portion of the care which was custodial was incidental to the primary reason for having private duty nurses to care for the tracheostomy and to take and record vital signs, report to the doctor and the next nurse on duty.

. contended that a precedent was set by Blue Cross of Rhode Island in issuance of a check for one of the claims as a CHAMPUS benefit; that the beneficiary survived only nine weeks during the home care circumstances and that the CHAMPUS definition of custodial care involving a prolonged disability is, in his opinion, not applicable; rather, the end was in sight; that the private duty nursing services were definitely not engaged for convenience or to provide personal services to the patient; that, rather, the personal services were incidental to the hiring of nurses to perform the skilled nursing duties; that Dr. Kashlan stated that the skilled nursing services required fifteen minutes of every hour; that in . . opinion, six hours a day were required for those services; that the nursing services were not "requested" by the physician but were "ordered" by the physician; that the beneficiary could not return home without the nursing services; that OCHAMPUS appears to interpret "primary" within the regulations, (Chapter IV.C.3.o.(5)) in terms of which services required the most time; that rather "primary" as used in the regulations in . opinion was intended to be consistent with the dictionary use of "primary" meaning "of the first rank, of prime importance; that the tracheostomy

care was the principle care provided and the "primary" care; that the peer reviewers in fact recognize that without the tracheostomy care that the beneficiary's life would have been terminated.

. . , disagrees with the OCHAMPUS calculations and the Home Care America calcuations as to the total cost of the private duty nursing services; that according to his records the total cost was $18,714 of which his insurance paid $9,309; that CHAMPUS paid $1,574.78 leaving a balance of $7,830.22; that he is not concerned about the provisions in the CHAMPUS regulations providing for coverage for prescription drugs since his insurance paid for most of that; that in his opinion the OCHAMPUS position is based on the inability of the Department of Defense to write a regulation properly; that it was not in his opinion, the intent of the Department of Defense to write a regulation denying benefits on the grounds of the impossibility to restore the patient to health; that the OCHAMPUS Statement of Position was received by him less than 48 hours prior to the hearing (4:00 p.m., September 20, 1983, with the hearing at 10:00 a.m. on September 22, 1983) and that it was undated; that in it Mr. Plicta and Dr. Rodriguez appear to agree with that the OCHAMPUS interpretation of the regulations was inhumane but that they appear to blame it on the regulations.

further testified that the nursing services were under the supervision of a physician; that the medically desired result was to sustain life until the cancer killed ; that the nursing services most required were the tracheostomy aspiration and insertion; that they had to use the suction device because the beneficiary still had problems with feeding (he would on occasion

cough food across the room onto the wall); that the nurse would have to stop feeding, use suction tubes, the saline solution, massage the beneficiary as necessary to dislodge the mucus and roll him over to suction the tracheostomy; that Dr. Kashlan estimated fifteen minutes of every hour of every day; that estimate was approximately four times each hour near the end of the beneficiary's life; most of the hours of care could have been rendered by an average trained adult but that was not the primary purpose of the nurse being there; that an adult could not take care of the tracheostomy; that a nurse could not come to the house, spend fifteen minutes, leave and come back, prepare herself to do the procedures and do them again, all in forty-five minutes; that the entire aspiration and suction procedures would sometimes take five minutes and sometimes take thirty minutes, being done as needed and not on a regular basis; that approximately six nurses were utilized, and the closest of these to residence was approximately fifteen miles away; that he does not know where the remainder of them lived but that visiting nurses who would come by on a predetermined schedule would not have been feasible and it would take an hour's travel to do fifteen minutes of nursing each time.

Further, that it is difficult to say who provided most of the personal services since he, his wife and daughter provided some of them but that the nurse possibly provided more than one-half of them overall since she provided them while the family slept; these services were incidental and not primary; the wife was at

home, he was employed and the daugnter was in school; that the wife was in serious emotional distress over their son's condition and imminent death; that LPN's were used instead of RN's because of the unavilability of the Registered Nurses (Exhibit 35, a letter from Home Care America documents this idea further); that he agrees with the OCHAMPUS position regarding the idea that the oral medications could be administered by an average trained adult although a nurse would be needed if it went into the beneficiary's lungs; as to changing positions of the beneficiary, it is questionable in his mind that the average trained adult could do that; that he disagrees with the OCHAMPUS position as to the ability of a trained adult to observe vital signs; that a nurse had to be present at the meals because of the tracheostomy problems.

Further, that Dr. Kashlan had stated that death could occur at any time, having said this prior to the insertion of the trach and that when the beneficiary returned home with the private duty nurses that his condition would be observable such that they would be able to bring him back into the hospital to die and they did: that the beneficiary was informed in 1977 that he had a five percent chance of a five year life span and that the expected life expectancy at that time was one year; that chemotherapy was administered by with what is called needle and slash medication on the beneficiary's back; that this procedure and other things that were performed were done by him because no other member of the family could do them; that most people could not do them; that there were things that could not be trained to do and

to observe; for example, prior to the beneficiary's death, the nurse knew death was imminent and he did not know.

EVALUATION OF THE EVIDENCE

The facts are not substantially in controversy in this appeal. Although the characterizations of the facts by on the one hand and by OCHAMPUS on the other hand are at odds, and although the contentions that arise from those characterizations are irreconcilable, the facts themselves are not substantially irreconcilable. Primarily, the troublesome areas with this appeal involve application of the regulations to those facts.

The evidence as a whole establishes beyond any reasonable doubt that the Beneficiary was suffering from a terminal cancer condition, that home care was an acceptable alternative to inpatient care, that he required all the nursing care described, that such care was medically necessary because his continued survival depended upon it, that the home care nurses provided tracheostomy and other airway care, that they also provided other nursing services as well as some of the essentials of daily living, and that some of those latter services could, and often were, provided by an "average adult with minimal instruction."

The one significant area where there is a possible factual divergence is in the formulation of the expert opinions by Dr. Kashlan on the one hand and by the peer review physicians on the other hand as to the amount of time necessary to provide the specific

medically necessary skilled nursing services. In the Home Nursing Certification Form signed by Dr. Kashlan (Exhibit 11, p. 40), he stated that the tracheostomy tube "needed suctioning every 15 minutes on the hour," in addition to care for "recurrent episodes of aspiration pneumonia." (This statement was apparently the basis for testimony that the suctioning required 15 minutes of every hour, but is actually more nearly reconcilable with other observations to the effect that the suctioning was performed approximately four times every hour.)

There is no statement in the record from anyone as to the precise amount of time required for the procedures on the average. testified that sometimes the procedures would take five minutes and sometimes thirty minutes. The peer review physicians were of the opinion that the skilled nursing services, principally related to this tracheostomy care would have required approximately two to three hours per day. There are no specific estimates by Dr. Kashlan or Dr. Al-Mulki that contrast with the peer review estimate.

urges upon us the contention that the principal reason for having the home care was to provide the tracheostomy care. This is fully supported by the record. He proceeds with the contention that the other services provided by the nurse were incidental to what he calls the "primary" care and that since the nurse had to be present full time to provide the primary care that it should logically follow that the incidental care is covered as well. Again, this is a matter of interpretation of the regulations and of characterization of the evidence, rather than a matter of

evaluating irreconcilable evidentiary positions, and will be discussed in greater detail in the section of this Recommended Decision entitled "Rationale."

RATIONALE

In order to resolve the disputed matters in connection with the claims involved in this case, it is necessary to examine the facts in the light of the regulations which are applicable. In doing so, the issues as framed present three areas of inquiry: (a) whether the services were medically necessary, (b) whether the services were custodial care, and (c) whether the services were intensified skilled nursing care within regulation DOD 6010.8-R, Chapter IV, c.3.o.

(a) Medically Necessary

There does not appear to be any dispute as to whether the services in controversy were medically necessary. The peer review physicians stated that the care "was medically necessary because his continued survival depended upon it." (Exhibit 19, p. 2)

(b) Custodial Care

Whether this case presents a case of custodial care is significantly controverted. OCHAMPUS submits that it was, and offers as precedents to two decisions issued at the ASD(HA) level in support of that position. Whether these precedents are controlling or are distinguishable will be dealt with later in this decision. First, reference will be made to the specific regulations defining and discussing "custodial care."

Chapter IV, E.12.a., in defining custodial care, contains as the various elements of that definition the following: that it is care rendered to a patient (a) who is mentally or physically disabled, (b) such disability is expected to continue and be prolonged, (c) the patient requires a protected, monitored and/or controlled environment, (d) the patient requires assistance to support the essentials of daily living, and (e) the patient "is not under active and specific medical, surgical and/or psychiatric treatment which will reduce disability to the extent necessary to enable the patient to function outside a protected, monitored and/or controlled environment."

The evidence readily justifies certain conclusions: that the Beneficiary was physically disabled, that the Beneficiary required a protected and monitored environment, that the Beneficiary required assistance to support the essentials of daily living, and that the Beneficiary's medical treatment was not considered likely to result in his being able to function outside of the protected and monitored environment.

The troublesome area is in determining whether the Beneficiary's disability was "expected to continue and be prolonged" as used in the regulation. OCHAMPUS has submitted that ". . . it is first apparent that the patient's physical disability was expected to continue and be prolonged. The patient's condition was characterized as progressive and terminal. (Exhibit 5, p. 3) In fact, the evidence in this case clearly supports the conclusion that the Beneficiary's condition was expected to continue." (Exhibit 27, p. 4)

In further support of its position, OCHAMPUS has submitted as precedents for this case two decisions in other cases at the ASD(HA) level. One of these decisions, number 82-05, is a decision in which the Beneficiary was found to have obtained custodial and domiciliary care while in a hospital for approximately three and one-half months prior to his subsequent transfer to a V.A. hospital and for the stated reason that "he could not be taken home since he lived in an icy and remote area where access was poor and because physical therapy was desirable." (Exhibit 29, Case No. 82-05, p. 2)

In that case the Beneficiary was admitted to the hospital, a malignancy was discovered, the Beneficiary received radiation, inhalation and physical therapies during the hospitalization, then improved, and was able to ambulate with assistance and a cane. The Beneficiary received no active medical treatment for approximately six weeks prior to his transfer, except for two seizure episodes. In that case the peer review physicians concluded that the care was custodial. The decision concluded that the care was custodial and skilled nursing services were not required except on a few specified occasions. The last approximately six weeks of the period were determined to be domiciliary care. Domiciliary care is not an issue in this case.

In that case the nursing services provided were those involving the essentials of daily living. The only service not occasionally provided by the Beneficiary's wife was the administration of oral medication which could have been provided without professional assistance as were the daily living type of services. As

to the hospitalization for the last six weeks, the ASD(HA) decis states the following: "The evidence in this field clearly estabi the primary reason for the hospitalization . . . was not for medic treatment but to provide a substitute home until weather conditi improved or the Veteran's Administration Hospital could accept transfer of the Beneficiary." (File 82-05, p. 5)

The ASD(HA) decision indicates that the Beneficiary wa deceased as of the date of the hearing, which was almost two yea after the hospitalization in controversy, but the decision does not reflect the date of death or any information regarding the prognosis as of the date of the case in controversy which might shed light on the extent to which the Beneficiary's illness in that case was anticipated to be "prolonged."

In the ASD(HA) Case File 06-80, the Beneficiary receiv services in a skilled nursing facility. The issues presented were "custodial care" and "the appropriate level of care." The discuss in the decision concludes with a summary as follows: "Notwithstar the level of care issue, this FINAL DECISION confirms the finding that the care rendered the deceased patient in this case was prin custodial in nature . . ." (Case File ASD(HA) 06-80, p. 17)

In that case the Beneficiary was confined to a skilled nursing facility for approximately eleven months as a result of severe brain damage due to anoxia following a myocardial infarcti He was initially treated in a civilian hospital, then transferred to a military hospital where he was confined for five months duri which the cardiac problems were brought under control but the pa- tient's mental disability did not improve. The care prescribed

at the military facility was conservative with no specific diagnostic procedures or treatment directed at the organic brain syndrome.

The Beneficiary in that case was then transferred to the skilled nursing facility to care for his residual neurological deficit. The eleven month confinement at that skilled nursing facility was the medical service in controversy in the appeal. Upon admission to the skilled nursing facility the Beneficiary's cardiac condition and general physical condition were listed as "good" but the organic brain syndrome was reflected in the Beneficiary being described as "uncooperative, combative, unable to adequately follow commands or verbally express himself, as well as having poor bladder control." (Case ASD(HA) Case No. 06-60, p. 5)

The Beneficiary in that case was kept in restraints and sedation for the greater part of his confinement. Secondary complications arose for which the treatment was essentially supportive. The Beneficiary was not readmitted to a hospital to care for exacerbations of his condition. The confinement concluded with the death of the Beneficiary, apparently resulting from complications from infections and ulcers. The nursing services principally involved care associated with the essentials of daily living, as well as decubiti care and some oxygen administration and suctioning during periods of respiratory distress.

Both of those cases are somewhat different from the .. case in the sense that in those cases the issue involves the Beneficiary's need to be maintained in some type of facility and the controversy involves whether the type of facility which was used to maintain or house the Beneficiary was an appropriate utilization

of that type of facility. In the case there is not a question of inappropriate utilization of a hospital or a skilled nursing facility. Those cases, however, are relevant to the case from the perspective of sheding light on how ASD(HA) interprets the regulation defining "custodial care."

This Hearing Officer is satisfied that many of the elements of custodial care are satisfied by the facts in this case. The subsidiary element of custodial care remaining as an issue for decision by this Hearing Officer is whether the Beneficiary's disability in this case was "expected to continue and be prolonged" as that term is used in the regulations. On the one hand, it is clear that it was "expected to continue." Thus the remaining issue for determination is whether it was expected to "be prolonged" as that term is used in the regulation.

In the Case No. 06-80, the Beneficiary's condition was essentially unchanged for approximately sixteen months, with confinement in the facility in controversy for approximately eleven months. In Case No. 82-05, the total period of confinement for the Beneficiary's condition is not apparent. The inpatient confinement in the facility in controversy was for approximately three and one-half months, and there was a period of confinement for an indeterminate time after that.

In the case, the private duty nursing services were provided for a period of approximately eight weeks out of a nine week period, punctuated by a readmission to the hospital after approximately seven weeks and terminated by a readmission

to the hospital culminating in death after the total period of approximately nine weeks.

In attempting to determine whether such confinement for the period of nine weeks is "prolonged" as used in the regulations, the ASD(HA) decisions do not provide conclusive precedential value, since the time periods involved in those other two cases were significantly greater. suggests that a dictionary definition of "prolonged" supports his contentions. His proffered definition is that prolong means "(1) to length in time, continue, (2) to lengthen in extent, scope or range . . ."

The evidence indicates that son's condition was expected to continue and that he was not expected to live for long: one physician suggested to that his son had less than six months to live, this occurring approximately four and one-half months prior to his son's death. Without any other Interpretations, precedents or other authorities, this Hearing Officer is of the opinion that common usage should be applied to determining the meaning of "prolonged." It is not felt that this term as generally used by persons in discussing lengthy illnesses would be applied to a confinement of eight or nine weeks. "Prolonged" means "lengthened" or "extended." Such a confinement would not be an "extended" confinement in general usage. Such a confinement is not comparable to the confinements illustrated in the two cases set forth by OCHAMPUS as precedents.

It is, therefore, the conclusion of this Hearing Officer that OCHAMPUS prevails on each and every element of the definition

that an "average adult with minimal instruction could have rendered most of the nursing services provided to the patient." (Exhibit 27, p. 8 and Exhibit 19, p. 3)

The OCHAMPUS position is based on the premise that health care funds may not appropriately be used to pay for a higher level of services than is necessary, e.g., that a skilled nurse should not be hired to perform a service which an attendant or hypothetical average trained adult could perform. The position is that a skilled nurse had to be there full time in order to provide the specific skilled nursing services when the need for them arose on an emergency basis. In this view, the services of a lesser nature provided by the skilled nurse are merely incidental and are performed while she is there for the purpose of providing her primary service. To paraphrase words, this view suggests that wnen you pay for the principal duties you get the others as part of the deal.

Chapter IV, paragraph C.3.o. does in fact provide benefits for intensified skilled nursing care in certain situations. The requirements for such covered benefits are set forth hereinafter. First, the care involves technical proficiency and scientific skills of an R.N. but can be provided by an L.P.N. where R.N.'s are unavailable. Such unavailability has been established by Exhibit 35. The nursing care must be ordered and certified to be medically necessary by the attending physician. This requirement is satisfied by Exhibit 35.

The nurses are required to maintain daily nursing notes even in a home setting, and did so in this case. Other regulatory

elements including the timelessness of submission of claims are not controverted in this record.

The nursing care, further, must "not, except incidentially, include services which primarily provide and/or support the essentials of daily living, or acting as a companion or sitter." There is no suggestion that the services in this case involving acting as a companion or sitter, but numerous of the services provided did in fact provide and/or support the essentials of daily living. Whether they did so "primarily" is a matter yet to be resolved in this decision and whether they did so "incidentially" is also a matter to be resolved.

Skilled nursing services are not covered, in accordance with Section (5), if they are "primarily those which could be rendered by the average adult with minimal instruction and/or supervision, ..." The facts demonstrate that many of the services could have been rendered by this hypothetical trained adult. Whether the nursing services were "primarily" such services as used in this subparagraph also remains to be resolved in this decision.

In subsection (6), additional requirements are imposed as follows:

> -"In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available for only a portion of the care, i.e., providing benefits only for that time actually required to perform medically necessary skilled nursing services."

-"In the event that full time private duty (special) nursing services are engaged, usually for convenience and/or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, . . . "

-". . . but in no event is less than one (1) hour of nursing care payable in any twenty-four (24) hour period . . ."

-"Such situations are often better accommodated through the use of visiting nurses. This allows the personal services, which are not coverable by CHAMPUS, to be obtained at lesser cost from other than an R.N."

-"Skilled nursing services provided by visiting nurses are covered under CHAMPUS."

The foregoing regulation indicates that there will be cases in which a distinction must be made between the actual skilled nursing services, on the one hand, and the "essentials of daily living" type of services (or "personal services") on the other hand, with benefits paid only for skilled nursing services. The regulation provides that such will be the case "in most situations."

This is so presumably in order to encourage proper utilization of skilled nurses, and thereby reduce health care costs. The means by which such may be done is to use visiting nurses when possible. The factual situation presented in this case does not

appear to be a case in which the use of visiting nurses would have been feasible to provide all of the care required by this Beneficiary. The feasibility of visiting nurses is not specifically documented by the peer review physicians and is not strongly asserted by OCHAMPUS. Similarly, the full time services were not retained "for convenience" or for the purpose of providing personal services to the Beneficiary.

Personal services were clearly provided, and the portion of the day spent in skilled nursing services appears to have been, at most, approximately three hours. However, the language of this subsection of the regulations does reflect that there will be situations where benefits are available beyond "that time actually required to perform" the medically necessary services.

In determining whether this case is one which should fall into (a) "most situations" catagory or (b) the exceptional catagory, reference must be made to the facts of the case and the conclusions reached by the peer review physicians.

If this is a "most situations" case, then . ..... is entitled to benefits for three hours of service per day; if this is the exceptional case, then is entitled to benefits for full time services.

In order to determine into which category the case falls, it is necessary to resolve the problems set forth above concerning the use of the terms "incidentally" and "primarily:" By the language of Chapter IV, subparagraph C.3.o.(4), to be covered, nursing care

> "does not, <u>except incidentally</u>, include services which <u>primarily</u> provide and/or support the essentials of daily living."

Subsection (4) thus requires a close look at the term "primarily." As defined in Webster's New Collegiate Dictionary (1973 Ed.), "primarily" means "1: for the most part: CHIEFLY 2: in the first place: ORIGINALLY." In this light, it appears that there were services provided which were "for the most part" or "chiefly" related to the daily living or personal services areas of nursing care.

If "except incidentally" was not contained in subparagraph (4), it would be a clear statement that private duty (special) nursing care simply does not include, by virtue of the regulation, those services which "primarily provide and/or support the essentials of daily living."

In the facts of this case, the incorporation of the words "except incidentally" in the regulation has a significant impact on the ultimate effect of the regulation, because if those services which are "primarily" personal services are rendered only "incidentally," then they are covered. On the other hand, if they are not "incidental," they are not covered.

Resort must be had again to the dictionary for the general usage of this term. The above-cited Webster's defines "incidentally" as follows: "1. by chance: CASUALLY 2: by way of interjection or digression: PARENTHETICALLY" and defines "incidental" as follows: "1: occurring merely by change or without intention or calculation 2: being likely to ensue as a change or minor consequence . . . syn see ACCIDENTAL."

Such a definition supports the relevance of the OCHAMPUS viewpoint that it is useful to compare the relative quantities

of the highly skilled services versus those capable of being performed by the hypothetical trained adult. This viewpoint suggests that the services which require the bulk of the time cannot, therefore, be "incidental." Further, it is relevant to note that those services capable of being performed by the hypothetical trained adult, referred to herein as "daily living" or "personal services," were not casual or accidental, since they were among the stated reasons for obtaining the nursing services. (See for example, Dr. Kashlan's letter, Exhibit 10) The language of subsection (4) thus requires that unless those "daily living" services are "incidental," they are not covered. They do not appear to have been "incidental."

Subsection (5) provides an additional perspective on this coverage determination where it excludes coverage for services which are "primarily" those capable of being performed by the hypothetical trained adult. "Primarily" as defined in the previously cited Webster's, means, as stated above, "1: for the most part: CHIEFLY 2: in the first place: ORIGINALLY."

Again, the weighing of the facts indicates that the services were, "for the most part," not the highly skilled services. On the other hand, the highly skilled services were of paramount importance and were, - insists, the main reason for obtaining the nursing services.

Notwithstanding, the regulation seems to require a quantification of the respective types of services. The services were, "for the most part" those which could have been performed by the hypothetical trained adult. The peer review physicians found as

much; their finding is not contradicted by the claimant's medical evidence, and ; himself admitted that he agreed with a substantial portion of what the peer review physicians concluded could be done by the hypothetical trained adult.

points out that no such "trained adult" was available to him. This is a bona fide problem, which the regulations do not answer in a manner which would be expected to be satisfactory to For example, where do you find and how do you train such a person on short notice, particularly considering the nature of the jobs to be performed? Is it realistic to expect that such persons can be found, when people suited by temperament and training to undertake those tasks would likely be nurses already, or holding a job of some sort, an unavailable?

Unfortunately, the only answer to that conundrum is not really an answer: the regulations pre-suppose the existence of such a person, and our system of evaluating the expenditure of funds for health care requires such a consideration, even if it does not seem very practical to do so in a particular case. It is clear from the regulations that an apportionment and partial payment is mandated; the evidence provides a reasonable basis for such payment: three hours of skilled nursing care out of twenty-four.

FINDINGS OF FACT

Based on the foregoing evidence of record, the Hearing Officer finds that:

(1) The claimant in this appeal is hereinafter referred to as the "claimant."

(2) The claimant is a retired service member, SSN

(3) The beneficiary was , deceased son of

(4) The beneficiary received private duty skilled nursing services in the home from February 22 to April 11, 1982, and from April 26 to May 6, 1982.

(5) The nursing services were provided by both Registered Nurses and Licensed Practical Nurses sent by the agency, Home Care America.

(6) The agency provided Licensed Practical Nurses in some occasions rather than Registered Nurses because of the unavailability of Registered Nurses in the particular area.

(7) These skilled nursing services were provided on a 24 hour per day, seven day per week basis.

(8) The beneficiary was a twenty year old male with the diagnosis of recurrent malignant melanoma with metastasis to the brain and spinal cord and multiple related medical problems, including recurrent aspiration pneumonia, progressive weakness that resulted in paralysis quadriplegia and multiple decubitus ulcers.

(9) After hospitalization in September 1981, the beneficiary was found to have a metastatic tumor to the left side of the upper portion of the spinal cord for which he received radiation treatments; a CT scan showed metastasis to the left posterior portion of the beneficiary's brain.

(10) A tracheostomy was performed on the beneficiary.

(11) He was released to his home by the attending physician on the condition that there was twenty-four hour per day skilled nursing care.

(12) The skilled nursing care was required, in substantial part, because of the tracheostomy. Normally simple matters like feeding the beneficiary were more difficult than they would have otherwise been.

(13) The procedures in connection with the tracheostomy involved the nurse opening the tracheostomy package, arranging gauze around the tracheostomy, getting saline solution out of the package, turning the suction device on, putting it in water and testing it, suctioning out the tracheostomy and the beneficiary's mouth, putting the beneficiary on his side to massage and loosen any blockage; putting water in his throat, to liquify any blockage. The procedure took five minutes on occasion or thirty minutes on occasion.

(14) These and other tracheostomy hygiene and suctioning procedures were required approximately every fifteen minutes, and otherwise as needed.

(15) The skilled nursing services were medically necessary services in the treatment of an illness or injury secondary to the beneficiary's terminal cancer.

(16) In the words of his father, the services were provided to the beneficiary in order to keep him alive until the cancer killed him.

(17) The nursing services were appropriate medical care.

(18) The tracheostomy procedures were skilled nursing services, as set forth in Chapter II. subsection B.161. which list tracheostomy aspiration and insertion as an example of skilled nursing services.

(19) The skilled nursing services were rendered to a patient who was physically disabled and whose disability was expected to continue.

(20) The beneficiary required a protected, monitored and/or controlled environment.

(21) The patient required assistance to support the essentials of daily living.

(22) The patient was not under active and specific medical surgical and/or psychiatric treatment which would reduce his disability to the extent necessary to enable him to function outside a protected monitored and/or controlled environment.

(23) The beneficiary's disability was not prolonged as that term is used in Chapter II, B 47.

(24) The skilled nursing services are classified as private duty (special) nursing services since they were rendered by private duty (special) nurses to an individual requiring intensified skilled nursing care which can only be provided with the technical proficiency and scientific skills of an R.N., being provided by L.P.N.'s on a non-availability basis as provided by Chapter IV, subsection C.3.o.

(25) The private duty (special) nursing services were ordered and certifified to be medically necessary by the attending physician, on an out patient basis.

(26) The private duty (special) nursing care did not involve primarily acting as a companion or sitter.

(27) The private duty (special) nursing care was not obtained primarily to provide the essentials of daily living.

(28) Although the tracheostomy care requires a skilled nurse, an average adult could be trained to perform some of the suctioning procedures.

(29) The nursing services were not limited to services which provided and/or supported the essentials of daily living.

(30) The nurses did provide approximately one-half of the essentials of daily living, particularly while the family slept. Other family members provided some of the personal services at other times.

(31) The intensified skilled nursing care provided included services which primarily provide and/or support the essentials of daily living; the provision of some of those services was not merely incidental.

(32) Although the private duty (special) nursing care included specific skilled nursing services which were of paramount importance to the beneficiary, the nursing care also provided services which are primarily those capable of being performed by a trained adult.

(33) Under the facts of this case, three hours of skilled nursing care per day were beyond the skill of the average trained adult and therefore are covered.

(34) Payment of a claim by Blue Cross of Rhode Island in serving as a fiscal intermediary does not estop either OCHAMPUS,

this Hearing Officer, or ASD(HA) from reaching a contrary conclusion based on the evidence of record and a sound interpretation of the regulations.

RECOMMENDED DECISION

It is the recommended decision of the undersigned Hearing Officer that the Formal Review decision dated July 1. 1983, over the signature of Donald F. Wagner, Chief, Appeals and Hearings, be reversed in part and modified in part as follows: that the care in question was not custodial care; that the care in question included both intensive skilled nursing care and services related primarily to providing and/or supporting the essentials of daily living; that some of the nursing services could have been provided by an average trained adult; that based on the record as it is now constituted, benefits for skilled nursing services in the amount of three hours per day should be allowed; and that prescription drugs would be covered if they were claimed.

WILLIAM E. ANDERSON,
Hearing Officer

October 26, 1983