ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

MAR 14 1984

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) FILE 84-02
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-02. 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 beneficiary as represented by his adoptive father, a retired officer of the United States Army. The appeal involves OCHAMPUS denial of coverage of the beneficiary's residential treatment at the Anneewakee Treatment Center after April 30, 1981. The Anneewakee Treatment Center is a CHAMPUS-approved residential treatment center (RTC). At the time of the hearing, July 22, 1983, the beneficiary was still enrolled in the RTC. Testimony at the hearing indicated that the beneficiary was to be discharged to his home in August 1983.

The evidence of record establishes that the beneficiary was covered by other insurance which was primary to CHAMPUS. The other insurance paid for the beneficiary's RTC care at the rate of 100% of the RTC charges for the first 2 months of the year and 80% of the RTC charges for the remainder of the year. Claims prior to April 30, 1981, were paid by CHAMPUS as the secondary payor; CHAMPUS paid the difference between the billed charge and the amount paid by the other insurance. The CHAMPUS share of the charges averaged about $365.00 per month. The record does not document the charges incurred by the beneficiary subsequent to April 30, 1981; however, it does establish that he continued residential treatment until some time subsequent to the hearing date of July 22, 1983. While it is not possible to determine an exact amount in dispute, that amount significantly exceeds the jurisdictional amount of $300.00 for an OCHAMPUS hearing.

The hearing file of record, the recorded hearing transcript, 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, which denied CHAMPUS coverage of the

beneficiary's RTC care after April 30, 1981, be upheld. The Hearing Officer's recommendation is based upon a finding that residential treatment care was not medically necessary and was not an appropriate level of care after April 30, 1981. The Hearing Officer found that the beneficiary could have been treated on an outpatient basis after that date. The Director, OCHAMPUS, concurs in this Recommended Decision and recommends that it be adopted as the FINAL DECISION.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, accepts the recommendation of the Director, OCHAMPUS, and adopts the Hearing Officer's Recommended Decision. The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS coverage of the beneficiary's residential treatment care received after April 30, 1981. This FINAL DECISION is based upon the appeal record as stated above.

FACTUAL BACKGROUND

The beneficiary was born on December 23, 1966, to the daughter of the sponsor. He was adopted by the sponsor and his wife at age 4. The beneficiary presents a long history of difficulties at home and at school and was placed under a psychiatrist's care at age 8. He was followed in the Fort Gordon Child Guidance Service from December 1972 until May 1976. At that time, he was diagnosed as suffering from Minimal Brain Dysfunction associated with hyperactivity and he was treated with Ritalin for a number of years. Between 1976 and 1978, the beneficiary lived with his natural mother in Colorado, but was returned to his adoptive parents, apparently because of his mother's inability to cope with his unruly behavior. There is evidence that he also suffered from child abuse, primarily at the hands of a stepfather, while living with his mother in Colorado.

In 1978, after returning to live with the sponsor, the beneficiary was hospitalized briefly with a combination of rage reactions, severe temper tantrums, and destructive behavior. The beneficiary also experienced significant academic problems. He was described as doing a number of unusual things when upset including grunting, stumbling and falling, making obscene noises, and having rapid and frequent temper tantrums. In November 1978, the beneficiary was again referred to the Child Guidance Service and from there, in early 1979, to a private practitioner. During 1979, the beneficiary showed a marked deterioration in behavior, both at home and at school, characterized by frequent outbursts of hostility. He was described as being virtually unmanageable at home. The civilian psychiatrist recommended residential treatment of approximately 6 months to 1 year. This course of treatment was based upon a diagnosis of unsocialized aggressive reaction and was intended to allow the beneficiary to work on impulse control and to learn to adapt to social situations.

The sponsor requested and received OCHAMPUS preauthorization to have the beneficiary placed in an RTC. The beneficiary was admitted to the Anneewakee Treatment Center on January 23, 1980, following preadmission evaluations. The record does not appear to document a specific diagnosis at admission. A psychological evaluation dated February 1, 1980, concludes that the beneficiary was of low average intelligence with indications of learning disabilities and dysfunction. It concludes that the diagnostic impressions for the beneficiary "are of a youngster with unsocialized, aggressive reaction of adolescence (308.4), depressive neurosis (300.4) and specific learning disturbance (306.1)." All of the CHAMPUS claims submitted on behalf of the beneficiary show the DSM-II diagnostic code of 308.4. This evaluation recommended that the beneficiary "receive treatment in a residential setting to increase self-esteem, reduce aggressive behavior, and remediate his learning disabilities." It was estimated that after 1 year of treatment, the beneficiary would demonstrate positive changes.

The record documents slow but significant progress in meeting the beneficiary's treatment goals. The beneficiary was transferred to an "open psychotherapy group" on March 24, 1981. He earned a "crest" on December 18, 1980, permitting increased privileges and off-campus visits. On March 16, 1981, the beneficiary entered an open classroom. The monthly treatment plan reviews prepared during February, March, and April, 1981, indicate that the beneficiary was showing improved self control. On March 16, 1981, OCHAMPUS determined that the beneficiary had made sufficient progress that a full-time residential setting was no longer required and that CHAMPUS cost-sharing of the RTC care would terminate on April 30, 1981. It is that decision that provides the basis for this appeal.

Subsequent to the OCHAMPUS decision to deny continued cost-sharing and the filing of appropriate appeal requests by the provider and the sponsor, significant additional documentation was provided to OCHAMPUS. In requesting a reconsideration of the OCHAMPUS decision, the RTC Clinical Director maintained that the beneficiary had made significant progress in controlling his behavior, but only in the context of the structured RTC environment. He also noted that the death of the beneficiary's natural mother in the fall of 1980 had caused emotional trauma with which the patient was only then (June 1981) beginning to come to terms. The Clinical Director opined that discharge at that time would be at a severe risk of loss of most of the gains the patient had made to that point and would have grave implications for the patient.

On September 15, 1981, the RTC also forwarded substantial additional medical documentation to OCHAMPUS. Therein, the Clinical Director noted that the beneficiary had continued making progress. He stated that the beneficiary had the prognosis for being able to leave the center and to function in a community based outpatient program, but only after an estimated 12 to 18 months of additional inpatient care. A psychological

reevaluation dated August 26, 1981, summarized the beneficiary's progress to that point as follows:

> "[The beneficiary] was admitted to the evaluation and observation unit of the Anneewakee Treatment Center for evaluation by the Professional Staff and for introduction to the Anneewakee treatment program. In this Unit, he participated in the therapeutic milieu, prescriptive education and in occupational, art, activity and recreational therapies. He also received individual and group psychotherapy. He quickly adapted to the unit structure and accepted limits imposed by the Staff. He carried out assigned tasks responsibly, expressed feelings and thoughts in group psychotherapy, and offered helpful suggestions to other patients. He was transferred to an outside group on 3-24-80.
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> "In the outside group, he participated in the therapeutic milieu, in vocational, activity, and recreational therapy. He also received individual and group psychotherapy. Initially, his behavior was often impulsive and inappropriate, and he had trouble getting along with other patients in his group. He was uncooperative with Staff and resented their supervision. He had trouble generalizing from one situation to another.
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> "His relationship with Staff improved and he often sought the help and advice of his group leaders. He became a leader in his group but tended to be too aggressive at times. His problems with generalizing continued. He received his Crest on 12-28-80. This award carries with it increased privileges and responsibilities and allows its recipient to begin off-campus visits with his family. He expressed interest in preparing himself for entrance into the formal classroom and his request to enter the classroom was approved on 3-16-81.
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> "He continued to improve his self-control. Other patients often complained that he was 'bossy' but clearly accepted his leadership. His classroom behavior was appropriate and he was generally able to talk about his feelings rather than act on them. His academic performance slowly improved."

That report concludes with the following diagnosis for the patient:

> "AXIS I: 307.22 Chronic Motor Tic Disorder (Improved)
> 312.00 Conduct Disorder Undersocialized, Aggressive (In Remission)
>
> AXIS II: 301.89 Immature Personality Disorder (Improved)
>
> AXIS III: Allergic Asthma, Controlled by Medication."

The prognosis for the patient was stated to be good.

Subsequent to the receipt of the additional documentation, OCHAMPUS referred the case for professional peer review. The peer review report dated October 22, 1981, confirmed the OCHAMPUS determination that continued inpatient care was not at an appropriate level after April 30, 1981, as follows:

> "1. Round-the-clock treatment in a residential treatment center was not required after April 30, 1981. Progress notes indicate that the patient showed good impulse control, reasonably good relationships with staff and peers, ability to participate in school and activities as early as March 1981 perhaps even earlier. The improved behavior was not transitory; it had been sustained over several months after gradual improvement.
>
> "2. Clinical findings do support the diagnoses:
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> "307.22 Chronic Motor Tic (improved) is documented throughout progress notes.
> 312.00 Conduct Disorder Undersocialized, Aggressive (in remission) clearly described in history and in progress notes for the first several months at the RTC. As noted above, the disorder remitted.
> 301.8 Immature Personality Disorder (improved) is reflected in the progress notes by behavior that is somewhat immature for age.
>
> "3. Outpatient treatment would have been appropriate after April 30, 1981. A transitional period of Day Treatment could have been considered.

"4. The patient is in the dull normal range which is adequate for him to benefit from active psychiatric treatment.

"5. Inpatient treatment in an RTC after April 30, 1981, is not the treatment of choice for the reasons indicated in answers 1 and 3.

"6. The RTC does provide a total therapeutically planned group living and learning situation. The record is vague about individual psychotherapy. It is mentioned a few times but not described, no indication of frequency. Therefore, the record does not document integration of individual psychotherapy. It does, however, clearly show the indication of group psychotherapy.

"7. The RTC does render services and supplies primarily related to the treatment of the mental condition. This is demonstrated by the treatment plan and the progress notes that described the various therapeutic activities related to the patient's symptoms and diagnoses."

Based upon the results of the peer review, the OCHAMPUS Reconsideration determination upheld the initial decision to deny CHAMPUS cost-sharing of RTC care after April 30, 1981. The provider requested a Formal Review on December 29, 1981, and the Formal Review Decision upheld the initial decision to deny CHAMPUS cost-sharing of RTC care after April 30, 1981. The right to request a hearing was offered to the provider in the Formal Review Decision, and a period of 60 days in which to request a hearing was allowed. However, no hearing request was received until December 6, 1982, after the deadline for requesting further appeal. This request was received from the provider and was denied by OCHAMPUS as untimely. As a result of an inquiry from Congressman Doug Bernard, Jr., OCHAMPUS reviewed the denial of a right to further appeal and discovered that the record did not show that the sponsor had been provided a copy of the Formal Review Decision at the time it was issued. For this reason, an additional right to request a hearing was offered to the sponsor. The sponsor's hearing request dated April 13, 1983, was accepted by OCHAMPUS.

With its December 6, 1982, request for further review, the RTC submitted a report of a neuropsychological evaluation of the beneficiary which had taken place on November 5, 1982. The report summarizes the results of the neurological studies as follows:

> "The neuropsychological studies indicate significant impairment of a generalized nature. The Sensory Perceptual Examination indicated significant errors at the level of finger tip number writing in which the right hand performed more poorly than did the left. At the level of central processing, [the beneficiary] shows a severe limitation in his ability to engage in abstraction and concept formation. The processing of factual information is done very poorly by the left upper extremity. The right upper extremity is shown to be limited in finger tapping. At an output level, [he] is found to show evidence of the aphasic symptoms of construction dyspraxia and spelling dyspraxia. In summary, [the beneficiary] shows impairment in the sensory input in central processing and in output."

In addition the following treatment considerations were raised by the clinical psychologist who provided the report:

> "The neuropsychological examination has indicated significant impairment in the functioning of [the beneficiary's] cerebral cortex. His most serious difficulties are in the area of the processing of ideas and in concept formation. [He] has a very limited ability to comprehend what is going on around him and can be expected to exercise poor judgment. He will require very simple instructions if he is to adequately comprehend and should be taught methods to aid in his ability to acquire and accurately process information. He needs to become aware of his impairment so that he can increase his understanding and begin to engage in more effective behavior. [The beneficiary's] response to treatment will be slower than originally anticipated due to the cerebral impairments. His treatment team will need to actively explore [his] ability to increase his comprehension and seek ways to help him more realistically perceive reality."

On May 2, 1983, the provider submitted additional medical documentation. This included a joint statement by the RTC staff psychiatrist and clinical psychiatrist. They state that it is their clinical judgment that during the entire duration of the beneficiary's stay at the RTC, outpatient treatment was considered inappropriate. Their report makes reference to the November 5, 1982, neuropsychological evaluation and to a new diagnosis (i.e., cerebral dysfunction and Tourette's Disorder)

formulated in April 1983. While acknowledging that the beneficiary had demonstrated progress in several areas, they assert that the beneficiary continued to have significant difficulties in interpersonal relationships. The beneficiary is described as frequently antagonistic, intimidating, argumentative, stubborn, demanding, and inconsiderate of the needs of others. The report states that the treatment objectives had been formulated to deal with the beneficiary's symptoms. It also states that they were working on a discharge date 6 to 8 months in the future. Also included with the April 1983 submission from the RTC is a report of a psychiatric reevaluation dated April 12, 1983. This report recapitulates the beneficiary's history and treatment. With respect to the period after the November 1982 neurological evaluation it states as follows:

> "In December, 1982, it was noted that [the beneficiary's] vocal tics were becoming more prominent and that they were especially severe when it was important for him to be quiet. He continued to require close supervision in group activities.
>
> "In February, 1983, he was reported to have a good sense of humor, was meeting his academic goals, and got along better with other patients. He was compliant with Staff.
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> "In March, 1983, he was no longer receiving asthma medication and was running track daily without wheezing. He was completing his academic goals. However, he was often argumentative with Staff and patients and annoyed others by sudden, loud yells which he justified by saying that he had "energy to burn." He had poor relationships with about half of the patients in his group because of his loudness, argumentativeness, and difficulty accepting criticism.
>
> "The use of Haloperidol to help him control his tics was discussed with [the beneficiary] but he refused to take it."

The newly formulated diagnoses as a result of this reevaluation were:

> "Axis I: 307.23 Tourette's Disorder
> 312.00 Conduct Disorder, Undersocialized, Aggressive (in remission)
>
> "Axis II: 301.89 Immature Personality Disorder (improved) (primary diagnosis)

> "Axis III: Cerebral Dysfunction with Soft Neurological Signs; Allergic Asthma."

The report concludes as follows:

> "[The beneficiary's] Conduct Disorder apparently is currently in remission but his Immature Personality Disorder, although improved, still causes [him] to annoy others, to have difficulty accepting sincere attempts to correct inappropriate behavior, and to provoke others by his impulsivity. The effects of his cerebral dysfunction can be clearly seen in his frequent inability to comprehend what is going on in his environment and to respond appropriately. His poor judgement is reflected in his ability to monitor his own behavior realistically with the result that he had trouble understanding how his behavior annoys others and frequently rejects attempts to help him correct it."

At the hearing the sponsor testified that there was no way the beneficiary could have come home in April 1981. His conclusion was based upon the beneficiary's behavior during home visits as shown in the medical records; the beneficiary's behavior made it impossible for him to live at home. The beneficiary's adoptive mother (grandmother) also testified that the beneficiary was not controllable in the home setting. The adoptive parents testified that they had seen major improvement in the months just prior to the hearing and they felt that the time was approaching when the beneficiary would be able to return home. Both parents attested to the fact that the primary insurance carrier had continuously paid for more than 80% of the RTC charges for the beneficiary's care without questioning its necessity. Other testimony adduced at the hearing was well summarized by the Hearing Officer as follows:

> "At the hearing, Dr. Jose Balbona stated that the progress notes were not written with the view of insurance claims but that the beneficiary had a thinking disorder. He was severely disturbed. He stated that the average length of stay in the Anneewakee Treatment Center was two years but [the beneficiary's] problems were severe and required longer treatment. He stated that he had given [the beneficiary] psychotherapy each week and although [he] was improved in the spring of 1981, he was still antagonistic. He stated that improved did not mean cured. He stated that the Anneewakee Treatment Center was conscious of

the problem of custodial care and tried to avoid that type of care. Dr. Balbona stated that he was not aware of any particular problem the beneficiary had in the spring of 1981 resulting in the beneficiary losing home visiting privileges or any trouble that the beneficiary incurred in those visits.

"Dr. Horace Stewart testified that the Anneewakee Treatment Center used the team approach in evaluating the patient's duration of treatment. He stated that the team consisted of a psychiatrist, a psychologist, a social worker, a nurse, a teacher and a unit supervisor. He stated that he was not on the team that evaluated the beneficiary's treatment plan and was not aware of all the considerations that went into the decision to continue his stay at Anneewakee Treatment Center. He stated that he did administered [sic] a psychological test to the beneficiary in November, 1982, some nineteen months after OCHAMPUS terminated benefits, which suggested that [the beneficiary's] progress was inconsistent and he still had problems. Dr. Stewart testified that the beneficiary could not be handled on an outpatient basis due to the neurological damage that he had suffered. The Anneewakee Treatment Center was design [sic] to improve the beneficiary's social skills and to teach alternate social responses to [his] explosive behavior. He stated that the science of psychology is just beginning now to understand and know how to help this type of behavior.

"He stated that one problem to consider in discharging a patient is that if the discharge is premature, an unsuccessful effort in coping on the outside would be injurious to the patient's rehabilitation.

"Dr. Robert Obst, a psychologist, stated that the nature of [the beneficiary's] problem was such that his treatment would take longer than most of the treatment problems the Anneewakee Treatment Center encountered. He stated that he had no personal involvement with the beneficiary and could only refer to the records. He did not treat the beneficiary nor did he serve on any of the treatment teams."

In addition to the foregoing, Dr. Stewart was asked to explain why he did not consider outpatient treatment appropriate in April

1981. He responded that he could only answer on the basis of hindsight; that is, on the basis of the November 1982 neuropsychological evaluation, the boy had generalized cortical damage. His ability, judgment, abstract thinking, and ability to behave in a socially appropriate manner are impaired. He stated that the cortical dysfunction could be expected to be lifelong, but residential treatment could improve function by providing a structured and supportive learning environment not otherwise available to the beneficiary. He testified that professional understanding of problems such as the beneficiary's is only now developing. Once the beneficiary's needs were more specifically known, the program was more tailored to meet them.

This appeal has now progressed in the CHAMPUS appeals procedure to the point where all levels of administrative appeal have been completed and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether residential treatment center care provided to the beneficiary after April 30, 1981, was medically necessary and at an appropriate level.

Medical Necessity

The Department of Defense Appropriation Act of 1981, Public Law 96-527, prohibits the use of CHAMPUS funds to pay, among other matters,

> ". . . any service or supply which is not medically or psychologically necessary to prevent, diagnose or treat a mental or physical illness, injury, or bodily malfunction . . . "

All subsequent Department of Defense Appropriation Acts have contained similar restrictions.

Paragraph A.1., chapter IV, DoD 6010.8-R, defines the scope of benefits for the CHAMPUS Basic Program as follows:

> "Scope of Benefits. Subject to any and all applicable definitions, conditions, limitations, and/or exclusions specified or enumerated in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury. . . ."

Specifically excluded from CHAMPUS coverage are all "services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury." (Paragraph G.1., chapter IV, DoD 6010.8-R.) "Medically necessary" is defined as "the level of services and supplies (that is,

frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury . . . Medical necessity includes concept of appropriate medical care." (Paragraph B.104., chapter II, DoD 6010.8-R.) "Appropriate medical care" is defined as:

> "a. That medical care where the medical services performed in the treatment of disease or injury, . . . are in keeping with the generally acceptable norm for medical practice in the United States;
>
> "b. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training or education and is licensed and/or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
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> "c. The medical environment in which the medical services are performed is at the level adequate to provide the required medical care."

CHAMPUS provides services for inpatient care; however, such care must be at an appropriate level. As provided in paragraph B.1.g., chapter IV, DoD 6010.8-R:

> "For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment . . . . If it is determined that the institutional care can reasonably be provided in the home setting, no CHAMPUS institutional benefits are payable."

Finally DoD 6010.8-R, chapter IV, G.3. provides that services and supplies related to inpatient stays in hospitals and other authorized institutions above the appropriate level required to provide necessary medical care are specifically excluded.

Care in an authorized psychiatric residential treatment center serving juveniles and adolescents is also a benefit of CHAMPUS. Such facilities are defined as follows:

> "'Residential Treatment Centers' means institutions (or distinct units of an institution) existing specifically for round-the-clock, long-term psychiatric treatment of emotionally disturbed children who have sufficient intellectual potential

> for responding to active psychiatric treatment, for whom outpatient treatment is not appropriate and for whom inpatient treatment is determined to be the treatment of choice. RTC's do not provide domiciliary and/or custodial care, but rather, must be able to provide a total therapeutically planned group living and learning situation within which individual psychotherapeutic approaches are integrated." (Paragraph B.155., chapter II, DoD 6010.8-R.)

The benefits available in such facilities include room and board, patient assessments, diagnostic services, psychological evaluation tests, drugs and medicines, and other necessary medical care. (Paragraph B.4., chapter IV, DoD 6010.8-R.)

The evidence of record establishes that the beneficiary suffered from a number of chronic disorders and that residential treatment was medically necessary and appropriate during the period of January 23, 1980, to April 30, 1981. The record also establishes that the beneficiary required additional treatment after April 30, 1981; however, the preponderance of the evidence, based primarily upon the medical records maintained by the inpatient facility, establishes that the beneficiary could have been treated on an outpatient or day care basis after April 30, 1981. Of particular significance is the psychological reevaluation prepared on August 26, 1981, quoted at length above. That document establishes that the beneficiary adapted quickly to the residential environment, participated constructively in individual and group psychotherapy, accepted responsibility, and was transferred to an outside group 3 months after his admission. The reevaluation continues to document continued progress in the outside group. His initial behavior in the group is described as impulsive and inappropriate, but significant progress is documented in that he was described as becoming a leader in his group preparing himself to enter the formal classroom, and actually entering the formal classroom on March 16, 1981. The record also establishes that the beneficiary's improvement prior to April 30, 1981, was not transitory, but was sustained over several months after gradual improvement. The professional peer reviewer who reviewed this case subsequent to the OCHAMPUS decision to deny CHAMPUS cost-sharing of RTC care after April 30, 1981, fully concurred with that decision.

The peer reviewer concluded that round-the-clock care in an RTC was not required after April 30, 1981; outpatient treatment would have been appropriate with a possible transitional period of day treatment. The medical evidence submitted by the facility subsequent to the peer review report shows a sincere attempt on the part of the facility to document and bolster its position that an inpatient setting was necessary subsequent to April 30, 1981. However, there is not sufficient evidence presented of a continuing requirement for inpatient care to outweigh the earlier evidence and its interpretation by OCHAMPUS and the peer

reviewer. The Hearing Officer reached essentially the same conclusion in his Recommended Decision as follows:

> "While the staff of the Anneewakee Treatment Center was unanimous in their testimony that the beneficiary's RTC [treatment] was medically necessary after April 30, 1981, only Dr. Balbona treated the beneficiary. While Dr. Balbona conducted weekly psychotherapy sessions with the beneficiary, he was unable to relate specific problems of the beneficiary to suggest that RTC was required. There were no disciplinary or developmental problems in the record, no medication and no related or unrelated health problems being addressed by the Anneewakee Treatment Center. While Dr. Stewart administered a psychological test of the patient seventeen months after the determination of CHAMPUS benefits, he was never on the treatment team of the beneficiary particularly in the period in question and could not speak to particular problems during that period.
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> * * * *
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> "While the beneficiary's parents stated that they were convinced that RTC was required, the only behavioral problems related were abusive language that the beneficiary engaged in on his infrequent home visits. The beneficiary did not get in trouble with 'the law' or become a 'substance' abuser and did not require medication for his psychological condition. The beneficiary was originally recommended to the Residential Treatment Center for a period of six months to a year. The subsequent evaluations by the Center continued to prolong the treatment period but the daily records do not reflect the particular problems suggesting the continuation. Indeed the records suggest that the beneficiary continually improved over the period of treatment. At the same time, the termination of Residential Treatment Care was being delayed.
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> "While Dr. Balbona stated that the Residential Treatment Center (RTC) was concerned that a premature discharge could harm the beneficiary, this appeared to be based on the philosophy of the institution rather than the beneficiary's failure to meet treatment goals."

The hearing file of record establishes that the beneficiary required continuing care beyond April 30, 1981. However, the greater weight of the evidence compels a conclusion that continued inpatient care at the residential treatment center was above the appropriate level and for that reason was not medically necessary.

SECONDARY ISSUES

Payment by the primary insurance carrier

The beneficiary's parents both emphasized the fact that the primary carrier never questioned paying in excess of 80 percent of the billed charges. They cited this as evidence that the primary insurance carrier considered the entire course of treatment medically necessary and at an appropriate level. However, the record contains no evidence of the payment policy or considerations given to the care by the primary carrier. Further, irrespective of the payment policy or actions of the insurance carrier, the OCHAMPUS determination must stand independent and be made only within the specific constraints of law and regulation by which the program operates. The actions of another payor are not relevant to the OCHAMPUS determination of an issue.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the inpatient residential treatment provided to the beneficiary after April 30, 1981, was beyond the appropriate level and was not medically necessary. The previous determinations to deny CHAMPUS cost-sharing for that care after April 30, 1981, are upheld. Issuance of this FINAL DECISION completes the administrative appeal process as provided under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

William Mayer, M.D.