ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

JUN 11 1984

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) FILE 84-07
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-07 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the wife of a retired officer of the United States Air Force. The appeal involves the denial of CHAMPUS cost-sharing of the appealing party's inpatient confinement at a skilled nursing facility from April 20, 1982, to May 20, 1982. The amount in dispute is $870.38, which is the 75% CHAMPUS cost-share should the billed charges of $1,160.50 be allowed.

The hearing file of record, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. The Hearing Officer recommended denial of CHAMPUS cost-sharing based on findings that the care was domiciliary and provided above the appropriate level of care. The Director, OCHAMPUS, concurs in the Recommended Decision and recommends its adoption as the FINAL DECISION by the Assistant Secretary of Defense (Health Affairs).

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, agrees with 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 cost-sharing of the inpatient stay at Heartland of Chillicothe, a skilled nursing facility, from April 20 through May 20, 1982, as excluded domiciliary care and as care provided above the appropriate level.

FACTUAL BACKGROUND

The beneficiary suffered a severe open fracture of her right ankle as a result of an automobile accident on January 12, 1982. Following the accident and subsequent surgery, she was confined to a hospital for a period of 5 weeks and was discharged on February 18, 1982, with her leg in a cast and the use of a walker. On March 27, 4 days prior to planned change of her leg cast, the beneficiary fell and fractured her right hip. She was

brought to the Ross County Medical Center emergency room where x-rays showed an intertrochanteric fracture of the right hip. She then underwent an "open reduction and internal fixation, insertion of Endel nailing, three rods with bone cementing of the distal portion of the femur, application of long leg Robert-Jones splint."

The discharge summary shows that while the beneficiary was in the hospital she cried easily and was easily upset. These episodes were described as "so called emotional problems." The physician discussed this with the sponsor and was told that "she is always like that." Although there was a brief (15 to 30 minute) psychiatric consultation with the hospital psychiatrist, Dr. Oppenheimer, no further consultations by Dr. Oppenheimer are noted in the record. On April 10, 1982, the patient started whirlpool with the right ankle and walker ambulation without weight which was fairly well tolerated. On April 18, 1982, the sutures were removed and the wound was described as dry with no evidence of infection. The discharge summary indicates the beneficiary was discharged on April 19, 1982; however, since she was transported directly to the skilled nursing facility, it appears her actual discharge was April 20, 1982.

The discharge plan called for the patient to be transferred to an extended care facility nursing home for continuing physical therapy. The physical therapist, Bill Musser, was to continue to follow the patient, and the treating physician, Dr. Lee, was to see the beneficiary in his office 2 weeks after her discharge from the hospital.

The record reflects that while at the skilled nursing facility, the beneficiary received physical therapy 5 days a week and went to the whirlpool 7 days a week. She was accompanied by an aide when she went to the whirlpool and a licensed practical nurse administered her medications. During her first 3 days, she was placed on bedrest. She then used a wheelchair for the next 2 weeks. During the last 1½ weeks of her stay, she used a walker when she went to the dining room. The beneficiary was twice taken by automobile to Dr. Lee's office for examination.

The beneficiary filed a claim with the CHAMPUS Fiscal Intermediary for the physical therapy and the inpatient stay at the skilled nursing facility. The physical therapy charge totaled $483.00 of which $395.40 was allowed and cost-shared. However, the fiscal intermediary denied CHAMPUS cost-sharing of the charges of $1,160.50 for the inpatient stay at the skilled nursing facility on the grounds that "custodial nursing care is not a benefit." The beneficiary requested a reconsideration, and the fiscal intermediary affirmed its initial denial.

By letter dated December 14, 1982, the beneficiary appealed to OCHAMPUS requesting a First Level Appeal determination. Before issuing its First Level Appeal determination, OCHAMPUS obtained a medical review of the claim by the Colorado Foundation for Medical Care. The matter was reviewed by two medical doctors,

one a specialist in orthopedic surgery and the other a specialist in internal medicine, resulting in the following opinion:

> "Was the medical environment (skilled nursing facility) at the level adequate to provide the required medical care for the period April 20 through May 20, 1982?
>
> "The skilled nursing facility was more than adequate level of care for this patient. Many patients like this go home from the hospital.
>
> "Were the services and supplies related to this inpatient hospital stay above the appropriate level required to provide the necessary medical care?
>
> "No. Physical therapy, medications and general care were appropriate services and supplies for this patient's care.
>
> "In your opinion, could the care have been provided on an outpatient basis for any of the time in issue?
>
> "Yes. This kind of care is often provided on an outpatient basis when these patients go home. Therapy can be provided in the patient's home, although the cost might not be any different.
>
> "In your opinion, could the care have been reasonably provided in the home setting during any of the period in issue?
>
> "Yes. Home care is a reasonable alternative for caring for these patients. Nothing in the records show that this patient could not have been cared for at home, although we don't know much about her old ankle injury or general health.
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> *
> *
> *
>
> "Did the patient receive services that could only have been rendered by a professional or licensed nurse?
>
> "No. She did not require a licensed nurse to provide her care."

On June 16, 1983, OCHAMPUS issued its Formal Review Decision denying cost-sharing of the stay at the skilled nursing facility for the period from April 20, 1982, through May 20, 1982. It was concluded that:

> "The services provided to this patient could have been provided in the home. The care provided, therefore, was domiciliary care. Services and supplies medically necessary in the diagnosis and treatment of a patient's medical condition, received while in a domiciliary care situation are authorized CHAMPUS benefits in the same manner as though the patient resided in her own home. Such benefits would be cost-shared as though rendered to an outpatient. In this case the patient received physical therapy by an individual provider in the skilled nursing facility which could have been provided in her home. Benefits are, therefore, available for physical therapy. Benefits for physical therapy have had been previously allowed."

The beneficiary appealed and requested a hearing. The appeal covers her claim for inpatient stay at Heartland of Chillicothe from April 20 through May 20, 1982. The total amount billed was $1,160.50. The amount in dispute is $870.38, which is the amount CHAMPUS would cost-share if the billed charges were allowed.

It was the beneficiary's contention that the following factors were not taken into consideration in the denial of cost-sharing: the seriousness of her prior ankle injury which had not fully healed; that she was legally blind; that she was suffering from "depression;" that the sponsor was suffering from "depression" due to a heart condition and was unable to assist the beneficiary; and, that the beneficiary's residence was not adequate for her condition because it was an unfinished basement of an unfinished home.

The treating physician, Young Soon Lee, M.D., in an August 5, 1983, letter to OCHAMPUS stated:

> "[The beneficiary] was in the hospital from 1-12-82 thru 2-18-82 [sic]. She was then transferred to the Heartland Nursing Home. She was transferred to the nursing home for the reasons that she was having some difficulty using a walker. She was on pain medication and having some mental problems. She lived more than 30 miles away from the hospital with physical therapy facilities. [The beneficiary] lives with her husband who is a cardiac patient and suffering from acute depression, and [the beneficiary] would be expected to care for her spouse rather than

> the appropriate role reversal. Heartland was the only care facility having therapy equipment available and where our therapists regularly visited.
>
> "In light of the above reasons, it was felt that this was the best way to treat this patient pending improvement in her condition that would make it safe for her to return to the home environment."

Though Dr. Lee cited the dates of hospitalization as January 12 through February 18, 1982, these were the dates of her initial hospitalization following the automobile accident. It appears that his letter is in reference to her second hospitalization for her dislocated hip.

The hearing was held on November 10, 1983, at Columbus, Ohio, before OCHAMPUS Hearing Officer Mr. Joseph L. Walker. Present at the hearing were the beneficiary and the sponsor. The Hearing Officer has issued his Recommended Decision and all prior levels of administrative appeal have been exhausted. Issuance of the FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are (1) whether the appealing party's inpatient confinement in a skilled nursing facility from April 20 through May 20, 1982, was domiciliary and (2) whether the care provided was above the appropriate level.

Domiciliary Care

Under 10 U.S.C. 1077(b)(1), domiciliary care is excluded from CHAMPUS coverage. The Department of Defense Regulation governing CHAMPUS, DoD 6010.8-R, implements this statutory exclusion in chapter IV, E.13., as follows:

> "13. Domiciliary Care. The statute under which CHAMPUS operates also specifically excludes domiciliary-care. This is another area that is often misunderstood by beneficiaries (and sponsors).
>
> "a. Definition of Domiciliary Care. Domiciliary Care is defined to mean inpatient institutional care provided the beneficiary, not because it is medically necessary, but because the care in the home setting is not available, is unsuitable, and/or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

"b. Examples of Domiciliary Care Situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable.

"(1) Home Care is Not Available. Institutionalization primarily because parents work, or extension of a hospital stay beyond what is medically required because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

"(2) Home Care is Not Suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not sufficiently responsible to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

"(3) Family Unwilling to Care for Individual in the Home. A child who is difficult to manage may be placed in an institution, not because institutional care is medically required, but because the family does not want to handle him or her in the home. Such institutionalization would represent domiciliary care, i.e., the family being unwilling to assume responsibility for the child.

"c. Benefits Available in Connection With a Domiciliary Care Case. Should the beneficiary receive otherwise covered medical services and/or supplies while also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services and/or supplies in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

"d. General Exclusion: Domiciliary Care is an institutionalization essentially to provide a substitute home - not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present which have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs/charges related to the

provision of domiciliary care. While a substitute home and/or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided."

Applying this authority to the facts in this appeal, the Hearing Officer concluded that the skilled nursing facility confinement from April 20 through May 20, 1982, was for domiciliary care and, therefore, excluded from CHAMPUS coverage. Following my review of the record in this appeal, I agree and adopt the Hearing Officer's findings on this issue.

It is the opinion of the medical reviewers in this case that the care provided to the beneficiary could have been furnished on an outpatient basis and that home care was a reasonable alternative. The reviewers also opined that the patient did not require the services of a professional or licensed nurse to furnish her care. These views were not factually rebutted by the appealing party. Rather, the beneficiary admitted during the hearing that there had been discussions of placing her in a nursing home instead of the skilled nursing facility. The skilled nursing facility was selected because the physical therapist who provided the beneficiary's therapy in the hospital furnished physical therapy at the skilled nursing facility.

The appealing party has cited certain prevailing circumstances as factors complicating her medical condition and necessitating her inpatient confinement in a skilled nursing facility. These factors included her husband's inability to care for her at home due to his medical and physical conditions. This circumstance, however, is essentially similar to the domiciliary care example in the above cited Regulation provisions where home care is not available because the patient lives alone.

The appealing party also urged consideration of her serious prior injury as a complicating factor necessitating her care in a skilled nursing facility. There is no medical evidence, however, documenting her prior injury as an aggravating factor in the treatment of her hip dislocation or requiring her inpatient setting.

As noted by the Hearing Officer:

> "It is apparent from reviewing the case file and from the hearing testimony that the beneficiary has endured a very difficult period. Aside from the handicap of blindness, the initial injury to the ankle combined with the untimely fall and fracture of the hip less than 3 months after the ankle injury presented a most trying situation."

The facts in this case, however, are not dissimilar from previous cases of domiciliary care considered by this office. For

example, in OASD(HA) case File 83-37, the beneficiary's "spouse had just been released from the hospital following a heart attack and his physician confirmed the sponsor's inability to care for the beneficiary." The situation in OASD(HA) 83-37 was similar to the facts in this case in that the beneficiary's spouse in this appeal was unable to care for the beneficiary because of the spouse's heart condition and depression. Additionally, the beneficiary in OASD(HA) Case File 83-37 was unable to use a cane or a walker which is also similar to the situation facing the beneficiary in this appeal. It was concluded in Case File 83-37 that the care was domiciliary.

In another hearing case, OASD(HA) Case File 82-05, it was asserted that inclement weather, the remote location of the beneficiary's home, and that the beneficiary's spouse's bad back prevented him from being able to assist the beneficiary were reasons for continuing an inpatient stay. It was concluded, however, that the care was domiciliary and excluded from CHAMPUS coverage.

In view of the evidence of record and the previous decisions of this office, I agree with the Hearing Officer's conclusion that the claim in issue was properly denied as involving domiciliary care.

Appropriate Level of Care

The CHAMPUS regulation, DoD 6010.8-R, chapter IV, C.1.g., requires institutional care to be at the appropriate level necessary to provide medically necessary treatment in order to be cost-shared under CHAMPUS. Although the Regulation generally excludes CHAMPUS coverage of services and supplies related to inpatient stays above the appropriate level of care, the Regulation specifically authorizes CHAMPUS cost-sharing of otherwise covered medical care in domiciliary care cases. Therefore, the appealing party's medically necessary physical therapy may be cost-shared under CHAMPUS despite finding that her care involves domiciliary care.

The testimony demonstrated that one of the major considerations in the beneficiary being admitted to the skilled nursing facility was that the physical therapist who was providing care at the hospital would continue to be available to provide her physical therapy. Based on the beneficiary's testimony, it appears that a nursing home was considered adequate but that the physical therapist would not have been available.

It is clear from the record that there were no skilled nursing services of any nature provided to the beneficiary. For the first 3 days, she was on bedrest and her meals were brought to her. Thereafter, she was taken to the dining area in a wheelchair until the last week and a half of her stay when she would use a walker. Although an aide accompanied her to the whirlpool and her medications were administered by a licensed practical nurse, the medical reviewers opined that the appealing

party did require the skilled services of a professional or licensed nurse. No medical evidence exists in the record to rebut the medical reviewers' opinion.

There is no dispute that the beneficiary needed physical therapy. In addition, I appreciate Dr. Lee's statement concerning the skilled nursing facility that "it was felt that this was the best way to treat this patient pending improvement in her condition so that it would make it safe for her to return to the home environment." The issue, however, is not what was the "best way to treat this patient" but what was medically necessary and the appropriate level of care under the CHAMPUS regulation. Clearly, the beneficiary could have been taken care of in a nursing home or in her own home. The fact the beneficiary found it more convenient to have access to the physical therapist at the skilled nursing facility does not justify the skilled nursing facility as the appropriate level of care.

The Hearing Officer concluded in his Recommended Decision that:

> "What is lacking in this appeal is evidence that [the beneficiary] experienced medical problems during the period April 20 - May 20, 1982, of a nature serious enough to warrant skilled nursing care. Recuperation for the beneficiary's injuries occurred through physical therapy, but the record is devoid of evidence establishing either the need for or the existence of skilled nursing services beyond physical therapy."

The Hearing Officer went on to conclude that the care rendered was above the appropriate level, I agree and adopt his findings on this issue.

SECONDARY ISSUE

Opportunity to Respond to New Issues Raised by OCHAMPUS.

At the hearing the beneficiary and sponsor maintained they did not have the opportunity to respond to new issues (domiciliary care) raised by OCHAMPUS and they did not receive the OCHAMPUS Position Statement in a timely manner. As noted by the Hearing Officer, there were no new issues raised by OCHAMPUS at the hearing. Rather, the domiciliary nature of the beneficiary's care was the issue addressed in the OCHAMPUS First Level Appeal determination. Therefore, the appealing party had approximately 5 months to prepare for the hearing.

It is unfortunate if a written OCHAMPUS Statement of Position arrives late; however, it is at the hearing that the issues are presented by OCHAMPUS and the appealing party or parties are given an opportunity to respond. If necessary, the Hearing Officer may keep the record open for a sufficient period of time to allow the beneficiary to respond to issues initially raised at

the hearing. In any event, neither this Office nor OCHAMPUS is foreclosed from raising a statute or regulation provision that would affect the determination even though the initial determination by the fiscal intermediary or the decision in the First Level Appeal determination failed to raise the issue.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the inpatient stay at the skilled nursing facility from April 20 through May 20, 1982, based on findings that the care was domiciliary and was above the appropriate level of care. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

for William Mayer, M.D.

84-07

RECOMMENDED DECISION
CLAIM FOR CHAMPUS BENEFITS
CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES

(CHAMPUS)

In The Matter Of:

Beneficiary:
Sponsor:
Sponsor SSN:
Hearing Date: November 10, 1984

This case is before the undersigned hearing officer pursuant to the appellant's request for hearing of the First Level Appeal determination. The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) has granted the appellant's request. The hearing was held on November 10, 1984, at Columbus, Ohio, pursuant to Regulation DoD 6010.8-R, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Chapter X, "Appeal and Hearing Procedures." The beneficiary, and the sponsor, , appeared at the hearing. OCHAMPUS was represented by William Voharas, attorney-at-law.

ISSUES

The specific issues to be determined are whether or not the charges associated with the beneficiary's inpatient confinement at Heartland of Chillicothe from April 20 through May 20, 1982, were properly denied under the CHAMPUS Regulation, DoD 6010.8-R, and further, whether such care was medically necessary and furnished at the appropriate level, as defined by the Regulation.

LAW AND REGULATIONS

Applicable sections of DoD 6010.8-R, hereinafter referred to as the Regulation, are cited herein:

CHAPTER IV-BASIC PROGRAM BENEFITS

A. General. The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. In many of its aspects, the Basic Program is similar to private medical insurance programs and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of Benefits. Subject to any and all applicabl definitions, conditions, limitations, and/or exclusions specified or enumerated in this Regulation, th CHAMPUS Basic Program will pay for medically necessa

services and supplies required in the diagnosis and treatment of illness or injury, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional provide as well as professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment.

E. Special Benefit Information.

13. Domicilliary Care. The statute under which CHAMPUS operates also specifically excludes domiciliary care. This is another area that is often misunderstood by beneficiaries (and sponsors).

a. Definition of Domiciliary Care. Domiciliary care is defined to mean inpatient institutional care provided the beneficiary, not because it is medically necessary, but because the care in the home setting is not available, is unsuitable and/or members of the patient's family are unwilling to provid the care. Institutionalization because of abandonment constitutes domiciliary care.

b. Examples of Domiciliary Care Situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable:

(1) Home Care is Not Available. Institutionalization primarily because parents work, or extension of a hospit. stay beyond what is medically required because the patient lives alone, are examples of domiciliary care provided because there is no other family membe or other person available in the home.

(2) Home Care is Not Suitable. Institutionalization of a child becaus a parent (or parents) is an alcoholic who is not sufficiently responsible to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family Unwilling to Care for Individua in the Home. A child who is difficult manage may be placed in an institution not because institutional care is medi ally required, but because the family does not want to handle him or her in the home. Such institutionalization

would represent domiciliary care, i.e. the family being unwilling to assume responsibility for the child.

c. Benefits Available in Connection With a Domiciliary Care Case. Should the beneficiar receive otherwise covered medical services and/or supplies while also being in a domici iary care situation, CHAMPUS benefits are payable for those medical services and or supplies in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

d. General Exclusion: Domiciliary Care is institutionalization essentially to provide a substitute home- not because it is medical necessary for the beneficiary to be in the institution (although there may be condition present which have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs/charges related to the provision of domiciliary care. While a substitute home and/or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided.

G. Exclusions and Limitations. In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other CHAPTERS of this Regulation, the following are specifically excluded from the CHAMPUS Basic Program:

1. Not Medically Necessary. Services and supplies whic are not medically necessary for the diagnosis and/c treatment of a covered illness or injury.

3. Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

8. Domiciliary Care. Inpatient stays primarily for domiciliary care purposes.

CHAPTER II-DEFINITIONS

B. Specific Definitions.

14. Appropriate Medical Care. "Appropriate Medical Care means:

a. That medical care where the medical services performed in the treatment of a disease or injury, or in connection with an obstetrical

case, are in keeping with the generally acceptable norm for medical practice in the United States;

b. The authorized individual professional provi er rendering the medical care is qualified t perform such medical services by reason of h or her training and education and is license and/or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

c. The medical environment in which the medical services are performed is at the level adequate to provide the required medical car

104. Medically Necessary. "Medically Necessary" means th level of services and supplies (i.e., frequency, extent, and kinds) adequate for the diagnosis and treatment of illness or injury (including maternity care). Medically necessary includes concept of appropriate medical care.

161. Skilled Nursing Service. "Skilled Nursing Service" means a service which can only be furnished by an RN (or LPN or LVN), 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 tracheotomy aspiration and insertion. 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.

EVIDENCE CONSIDERED

The hearing officer has carefully considered all evidence, including the hearing testimony, the arguments made, the briefs submitted, and the documentary evidence in the hearing file.

SUMMARY OF THE EVIDENCE

During the period April 20 through May 20, 1982, the beneficiar was an inpatient at Heartland of Chillicothe, a skilled nursing facility located in Chillicothe, Ohio. The stated diagnosis was " R. hip intertrochanteric fracture, compound fx., dislocation of R. ankle". The injuries were sustained in a fall on a cement floor. The beneficiary had been hospitalized for treatment of the injuries from March 27 to April 20, 1982 (exhibits 1 and 6). According to the beneficiary (exhibit 14), she suffered a severe open fracture of the right ankle in an automobile accident on January 12, 1982. She was confined to the hospital for a period of five weeks and discharg with her leg in a cast and using a walker. She then suffered the fa on March 27, 1982, fracturing the right hip. Physical therapy was given during the skilled nursing facility stay.

The beneficiary filed a CHAMPUS claim with Mutual of Omaha Insurance Company, the CHAMPUS fiscal intermediary at that time, covering both the room and board charges of the facility as well as charges for physical therapy. The intermediary cost-shared the physical therapy services, but rejected the balance of the claim ($1,162.50) on the grounds that "custodial nursing care is not a benefit." (exhibits 1 and 2)

On October 7, 1982, [redacted] wrote to the intermediary, requesting a review of the decision made in her case (exhibit 11), enclosing medical records and a letter from the orthopedic surgeon, Dr. Young Soon Lee. The intermediary responded to the appeal on October 26, 1982 (exhibit 12), however the initial decision was upheld on the grounds that the services were "of a custodial nature. The claim was then referred for reconsideration since the amount in dispute exceeded $300.00. The reconsideration decision again upheld the denial of benefits for the same reasons stated in the review decision (exhibit 13).

Subsequently, [redacted] pursued her right of appeal in the matter by requesting a First Level Appeal determination by OCHAMPUS (exhibit 14). In her letter, the beneficiary stated that her nursin home stay was neither "long-term" nor for a "degenerative" condition but was, in fact, a "short term stay designed to enable me through therapy and medication to maximize my recovery." In its handling of the appeal, OCHAMPUS requested evaluation of the file by the Colorad Foundation for Medical Care, a professional peer review organization (exhibit 16). On June 16, 1983, OCHAMPUS issued its Formal Review Decision (exhibit 18), the summary of which is as follows:

> "The inpatient stay was not custodial in nature, because the patient's care was aimed at reducing the disability to the extent necessary to enable her to function outside the nursing facility. The care was aimed at reducing the disability with 1) open reduction of the hip fracture, and 2) physical therapy to restore the patient's ability for weight bearing and ambulation. The care was active and specific medical treatment which enabled her to leave the facility on a walker and progress to a quad cane and the patient was enabled to function outside a controlled environment.
>
> Review of this case file, as supported by the medical

reviewers, does not verify any skilled nursing care was required or provided. The patient needed assistance with t activities of daily living until her physical therapy enabled her to become ambulatory and independent again.

The skilled nursing facility was not the appropriate level of care for the period April 20, 1982 through May 20, 1982. The services provided to this patient could have been provided in the home. The care provided, therefore, was domiciliary care. Services and supplies medically necessar in the diagnosis and treatment of a patient's medical condition, received while in a domiciliary care situation are authorized CHAMPUS benefits in the same manner as thoug the patient resided in her own home. Such benefits would be cost-shared as though rendered to an outpatient. In this case the patient received physical therapy by an individual provider in the skilled nursing facility which could have been provided in her home. Benefits are, therefore, available for physical therapy. Benefits for physica therapy have been previously allowed."

On August 18, 1983, the beneficiary wrote to OCHAMPUS for the purpose of requesting a hearing. A second letter from Dr. Lee was included with the hearing request (exhibits 19, 20). The matter wa: then referred to the undersigned hearing officer and the hearing wa: held on November 10, 1983.

Additional documentary evidence is included in the hearing record, as follows:

Exhibit Number	Description
23	Notice of Hearing letter
24	Statement of OCHAMPUS position
25A&B	Letter to hearing officer from beneficiary with hospital discharge summary dated April 18,1
*26	OCHAMPUS response to Exhibit 25 dated December 14, 1983 (addendum to OCHAMPUS position)
*27	Letter to hearing officer from beneficiary dated December 22, 1983 in response to OCHAMPUS addendum.

* These exhibits were received subsequent to the hearing.

At the hearing, Mr. Voharas presented the OCHAMPUS position both by exhibit and by testimony. It is the position of the agency

that the services at issue are not covered because (1) the services were neither medically necessary nor furnished at the appropriate level, and (2) there is no evidence that a registered nurse type service was provided at the facility, with the exception of physical therapy. The care could have been provided at the beneficiary's home with minimal training.

The beneficiary and sponsor testified extensively at the hearing. Their main contentions are as follows:

-[illegible] medical care was a "continuous process" from January 12 to May 20, 1983.

-The beneficiary has been legally blind since 1955.

-The beneficiary became hysterical after breaking the hip and was treated for depression by a resident psychiatrist.

-Following hospital discharge, the physician had to make a choice as to Mrs. [illegible]' continued care. According to OCHAMPU most patients go home, but [illegible] had three additional problems - (1) a husband in depression and not able to furnish support, (2) her blindness, and (3) the original ankle injury. She therefore required someone to look after her, to assist in medication, to watch for depression, and to administer physical therapy. Only Hearland has a physical therapy facility, and additionally is a skilled nursing facility. In the absence of an SNF confinement, [illegible] feels she should have remained in the hospital.

-In answer to a hearing officer question, [illegible] said that there were no problems with the surgery itself and that his wi made a good recovery except for depression and the ankle injur Her temperature was monitored frequently due to the possibilit of infection to the ankle.

-At the SNF, the beneficiary was somewhat ambulatory with a walker upon admission but used a wheelchair due to depression and unsteadiness. The physical therapy, which was administere Monday through Friday, included range of motion exercises, manipulation of the ankle and knee, and work towards a weight bearing status.

-Daily routine at the facility was reported as follows:
  - -Once daily she was accompanied to the whirlpool by an aide.
  - -Twice daily, an LPN administered medication for pain and depression.
  - -She had severe diarrhea during the stay.
  - -For the first three days, meals were brought to the patient, afterward she went to the dining room in her wheelchair except for the last 1½ weeks during which she used a walker.

-Twice during the confinement, the patient was taken to Dr. Lee's office for checking of her mobility. Transportation was by private car. Dr. Lee does not come to the facility. The "house" physician is Dr. Smith who is required to see

patients once per month.

-Beneficiary suffered depression when in the hospital and was seen by a psychiatrist. No further psychiatric care was furnished at Heartland.

-Beneficiary should not have left the hospital, according to her husband. The only institution in the area with physical therapy facilities was Heartland. The care furnished by the SNF was a "mix" between skilled and domiciliary care.

-The beneficiary's temperature had to be monitored due to the possibility of infection from the ankle injury. While in the hospital, foot pulse and color were checked and at the SNF, the therapist monitored progress of the ankle. Intravenous antibiotics were given at the hospital, but not at Heartland.

-The beneficiary and sponsor object to the change of issues by OCHAMPUS, from custodial care to that of domiciliary, and care not furnished at the appropriate level. The parties contend that they were not given sufficient opportunity to addres the new issues.

-The beneficiary and sponsor feel that the case should be decic in their favor because it doesn't fall under ordinary circumstances due to the patient's mental condition, the non-healing of the prior injury, and the sight handicap.

Subsequent to the hearing, the beneficiary wrote to the heari officer, with a copy to OCHAMPUS, enclosing the discharge summary from Medical Center Hospital, dated April 18, 1982. The beneficiar additionally noted that "there were serious complications due to the unhealed previous ankle injury" and that "the need for further care and therapy is in the record." The beneficiary further commer ed on the fact that the OCHAMPUS position paper arrived after the hearing, denying them the opportunity to address new issues raised (exhibit 25 A&B). On December 14, Mr. Voharis responded to the nev evidence with an addendum to the OCHAMPUS Position Statement. According to OCHAMPUS, the discharge summary does not indicate impaired mental functioning or coordination, requiring SNF care. Secondly, although the discharge summary mentions a low-grade feve it contains no reference to fear of continued infection or for the need of continued treatment. Further, it is the OCHAMPUS opinion that there were no significant symptoms or problems upon discharge for which skilled nursing care would be required (exhibit 26). On December 22, 1983, the beneficiary and sponsor again wrote to the hearing officer, restating their position in the appeal (exhib 27). Mr. Voharas advised the hearing officer by telephone on Jan- uary 5, 1984, that OCHAMPUS had no further comment and at that point the hearing record was closed.

EVALUATION OF THE EVIDENCE

It is apparent from reviewing the case file and from the hearing testimony that the beneficiary has endured a very difficult period. Aside from the handicap of blindness, the initial injury to the ankle combined with the untimely fall and fracture of the hip less than three months after the ankle injury presented a most trying situation. The relevant facts to be considered, then, involve the complexity of that medical condition, the status of the patient upon discharge from the hospital, the nature of the post-hospital care, and the patient's progress thereunder. The question to be resolved is whether the treatment given can be matched to the medical problems presented, within the framework of the Regulation.

With regard to the extent of injury and status upon discharge the hearing officer must examine several types of evidence, including (1) documentation from the hospital or SNF medical records, (2) comments of the attending physician, (3) the opinions of other medical professionals, and (4) the testimony of the parties. The hospital discharge summary, dictated by Dr. Lee (exhibit 25 B) indicates final diagnosis to be "right hip intertrochanteric fracture" and "compound fracture dislocation of the right ankle with deep soft tissue injury." Surgery was performed on March 27, 1982 (open reduction with internal fixation) and repeated x-rays of both the hip and ankle showed "no change in position." The summary mentions two other medical problems, including "a low grade fever which was under control" and the fact that "the patient cries easily and is easily upset....", the latter improved by the administration of Desyrel. was "discharged on April 19, 1982 in an uneventful condition." She was "instructed in active ankle, knee and hip motion" and transferred to Heartland "for continuing physical therapy." The discharge summary makes no mention of the need for skilled nursing care. In Dr. Lee's September 15, 1982 letter, it is stated that was transferred "for continuing physical therapy and medication." (exhibit 10). In his August 5, 1983 letter, Dr. Lee stated that she was transferred to Heartland "for the reasons that she was having some difficulty using a walker" and that "she was on pain medication and having some mental problems." Dr. Lee also stated that "she lived more than 30 miles away from the hospital with physical therapy facilities" and that due to her husband's own medical problems, "Mrs. would be expected to care for her spouse rather than the appropriate role reversal." (exhibit 19)

A review of the progress notes of the skilled nursing facility indicates that physical therapy was administered with primary goals being to increase range of motion and become weight bearing and ambulatory. Medications administered included Darvocet, Desyrel, Tylenol, Lomotil and Dalmane. Further documentary evidence as to the beneficiary's activities during the stay at Heartland is limited. According to the beneficiary's testimony, however, her daily routine included trips to the whirlpool, twice-daily visits by an LPN, and early in the confinement, meals in the room. Of particular interest is that there were only two physician treatments during the stay and both times the beneficiary left the facility to go to the physician's office. Although the record includes testimony about post-surgical infection and fever as well

as emotional problems, it appears that these problems became minor considerations during the SNF stay, as evidenced by the absence of written documentation from either Dr. Lee or Heartland.

The physical therapy program administered to the beneficiary was obviously successful, with substantial gains noted in the records in the areas of range of motion, weight bearing capability and ambulation. Of primary concern to the hearing officer, howeve is why an inpatient stay was necessary in a skilled nursing facili The record does not support either the need for or existence of skilled nursing care. That view is shared by the peer review physicians whose analysis is reflected in Exhibit 17, specifically in the answers to OCHAMPUS questions 10,11 and 12:

> "10. If you felt that care could have been provided in the homesetting during any of the period in issue, would this patient have required at least one hour of skilled nursing care per day?
>
> We're not sure she required skilled nursing care unl physical therapy is considered skilled nursing care. If it is, then she required skilled care.
>
> 11. Did the patient receive services that could have only been rendered by a professional or licensed nurse?
>
> No, she did not require a licensed nurse to provide her care.
>
> 12. What were the services and for how long each day?
>
> There were no services required by a licensed nurse.

The beneficiary and sponsor raised two issues in their testimony which should be addressed. First, they maintain that they have not had the opportunity to respond to new issues raised by OCHAMPUS. They stated that the original basis for denial was that the care was "custodial" and that the issue of medical appropriateness was not raised until the formal review. Secondly, the parties maintain that because they did not receive the OCHAMPU Position Statement in time for the hearing, they could not address the "domiciliary care" issue raised by OCHAMPUS in that document.

With respect to the first issue, the hearing officer notes that the Formal Review Decision was prepared on June 16, 1983 - five months prior to the hearing - seemingly a sufficient amount of time to prepare. In addition, review of the Formal Review Decision (exhibit 18) clearly discusses domiciliary care on pages 4 and 5. With regard to the late filing of the OCHAMPUS Position Statement, there is no requirement in the CHAMPUS Regulation that the agency even file such a document, as noted by Attorney Voharas in Exhibit 26. Further, the parties were given full opportunity to testify at the hearing and to present post-hearing documentary evidence prior to the closing of the record on January 5, 1983.

RATIONALE

The evidence of record in this particular case points rather strongly to one conclusion - the beneficiary was admitted to the skilled nursing facility because she needed physical therapy and could not practically receive that treatment in any other setting. No credible evidence has been brought forth that would establish the medical necessity for care furnished in a protected, controlled environment with 24-hour nursing services. The need for physical therapy, of course, has not been questioned. The evidence suggests, however, that such therapy could have been safely performed elsewhere, for example, in the home.

The CHAMPUS Regulation is quite specific that:

(1) the services must be medically necessary, or adequate for the diagnosis or treatment (II.B.104)

(2) the services must be "appropriate medical care" (II.B.14.a)

(3) the services may not be above the appropriate level required (IV.G.3)

(4) for a service to be considered a skilled nursing service, it must be of the type which can only be performed under the supervision of a physician (II.B 161)

(5) if institutional care is provided not because it is medically necessary, but because care in the home setting is not available, is unsuitable, and/or members of the patient's family are unwilling to provide the care, it is deemed domiciliary care, and is not covered (IV.E.13)

What is lacking in this appeal is evidence that Mrs. experienced medical problems during the period April 20 - May 20, 1982 of a nature serious enough to warrant skilled nursing care. Recuperation from the beneficiary's injuries occurred through physical therapy, but the record is devoid of evidence establishing either the need for or existence of skilled nursing services beyond physical therapy. Obviously, the beneficiary's overall medical situation dictated supervision and assistance. Those activities are not of the type for which skilled nursing care and institutional confinement are indicated, however. The unsuitability of home care is duly noted (ref. exhibit 20, letter to OCHAMPUS from beneficiary: "....the patient's residence was the unfinished basement of an unfinished home that had no running water or toilet facilities."), as is the inability of the beneficiary's husband to care for her (from testimony). The Regulatic is quite clear, however, that such difficulties cannot be consider in establishing whether or not the care was domiciliary in nature.

FINDINGS OF FACT

The undersigned hearing officer makes the following specific findings of fact:

(1) the beneficiary, was an inpatient at the Heartland of Chillicothe (Ohio), a skilled nursing facility, during the period April 20 - May 20, 1982. The confinement followed a three-week hospital stay for treatment of an intertrochanteric fracture of the right hip and dislocation of the right ankle.

(2) Beneficiary filed a CHAMPUS claim with Mutual of Omaha Insurance Company in the amount of $1,162.50 for room ar board with nursing care, and $468.00 for physical therap The intermediary cost-shared the latter charge, but denied the fee of Heartland on the grounds that "custodi care is not a benefit."

(3) Beneficiary subsequently requested a review and (later) a reconsideration, but the intermediary affirmed its initial decision.

(4) Upon appeal to OCHAMPUS (First Level Appeal), the agenc found that although the care was not "custodial" the claim could not be allowed because there was no evidenc that skilled nursing care was "required or provided," and that the care furnished was "domiciliary care" and services could have been provided in the home.

(5) Beneficiary requested a hearing on the matter which was held before the undersigned on November 10, 1983, at Columbus, Ohio.

(6) The evidence of record supports a conclusion that the claim at issue was properly denied in that the care furnished was domiciliary care (6010.8-R, IV.E.13), it was not skilled nursing care (II.B.161), it was above the appropriate level (IV.G.3) and it was not medically necessary (II.B.104).

RECOMMENDED DECISION

It is the recommendation of the undersigned hearing officer that the First Level Appeal determination of OCHAMPUS be affirmed on the grounds that the services provided are not covered benefit. under CHAMPUS Regulation DoD 6010.8-R, Sections IV.E.13, II.B.161 IV.G.3, and II.B.104.

Joseph L. Walker
Hearing Officer

Columbus, Ohio
January 27, 1984