HEALTH AFFAIRS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

27 NOV 1984

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) Case File 84-28
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-28 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary, as represented by her guardian and sponsor, a retired member of the United States Army. The appeal involves the denial of CHAMPUS cost-sharing of inpatient care and related professional services for treatment of Alzheimer's disease provided May 6 through June 22, 1982, and August 1 through September 20, 1982. The amount in dispute is approximately $12,317.

The hearing file of record, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that CHAMPUS cost-share inpatient care at Eastern State Hospital from April 29 through May 5, 1982, (previously authorized by OCHAMPUS) and deny cost-sharing of the inpatient care provided May 6 through June 22, 1982. Inpatient care provided at Sacred Heart Medical Center August 1 through August 10, 1982, was recommended for cost-sharing by the Hearing Officer. Care from August 11 through September 20, 1982, was recommended for denial of cost-sharing, except for laboratory tests, an EEG, and a CT scan. The Hearing Officer also recommended cost-sharing of physician services for only the period of care August 1 through August 10, 1982. One hour of skilled nursing services per day and prescription drugs were also recommended for cost-sharing from May 6 through June 22, 1982, and August 11 through September 20, 1982. These recommendations were based on findings by the Hearing Officer that inpatient care provided May 6 through June 22, 1982, and August 11 through September 20, 1982, was custodial and excluded from CHAMPUS coverage.

The Director, OCHAMPUS, concurs with the Hearing Officer's Recommended Decision and recommends its adoption by the Assistant Secretary of Defense (Health Affairs) as the FINAL DECISION

provided the recommendation to cost-share the laboratory services, EEG, and CT scan are rejected as inconsistent with a finding of custodial care.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, adopts and incorporates by reference the Hearing Officer's Recommended Decision, as modified in accordance with the recommendation of the Director, OCHAMPUS, to authorize CHAMPUS cost-sharing of inpatient care and related professional services provided April 29 through May 5, 1982, and August 1 through August 10, 1982; but to deny CHAMPUS cost-sharing of the inpatient care and professional services provided May 6 through June 22, 1982, and August 11 through September 20, 1982, except for 1 hour per day of skilled nursing services and prescription drugs. This FINAL DECISION is based on finding the care denied cost-sharing constituted excluded custodial care.

In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence in this appeal. The findings are supported by the Recommended Decision, the appeal record, and applicable authorities with the exception discussed below. With the modification stated below, the Recommended Decision is acceptable for adoption as the FINAL DECISION by this office.

As the Recommended Decision and this FINAL DECISION partially reverses the OCHAMPUS Formal Review Decision in this appeal, a statement of my reasons for this action is appropriate. The Hearing Officer found the hospitalization from August 1 through August 10, 1982, was medically necessary diagnostic/ stabilization intervention and was not custodial care. The Hearing Officer primarily relied on an opinion of an American Psychiatric Association medical reviewer discussing the stabilization of the patient's Alzheimer's disease in the hospitalization of April 29 through May 5, 1982. I also find these comments to be persuasive; however, the necessity of a diagnostic admission is not well established in the record. The beneficiary was first diagnosed with Alzheimer's disease in 1976, and no information in the file indicates this diagnosis was open to question. Alternatively, as discussed by the Hearing Officer, inpatient care for an acute exacerbation of the condition for which custodial care is being received may be cost-shared by CHAMPUS if medically necessary. The Hearing Officer noted this exception to the custodial care exclusion does cover some aspects of this case, but determined this situation was more appropriately termed a medically necessary diagnostic/ stabilization intervention. I reject the Hearing Officer's determination that the patient's situation should be termed a medically necessary diagnostic admission. Further, I do agree with the Hearing Officer's finding the beneficiary's condition on August 1, 1982, constituted an acute exacerbation of the custodial care condition - Alzheimer's disease. I also concur in her findings that inpatient care was medically necessary for a short period to attempt stabilization of the beneficiary's

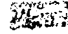
condition for potential return to home or transfer to a nursing home/skilled nursing facility. As the beneficiary was returned to home after the hospitalization in May/June 1982, I find a brief period of hospitalization with this goal a reasonable medical course. I find, however, that the beneficiary was receiving custodial care during August 1 through August 10, 1982, as stabilization would not reduce the disability to the extent necessary for the beneficiary to live outside a protected and controlled environment. Therefore, I find the beneficiary suffered an acute exacerbation of the custodial care condition and required a brief period of hospitalization to stabilize her condition. As an exception to the exclusion of custodial care, I find cost-sharing is authorized from August 1 through August 10, 1982, specifically for medical treatment of an acute exacerbation of her custodial condition.

I must disagree, however, with the Hearing Officer's recommendation to cost-share the laboratory charges, EEG, and CT scan. As stated by the Hearing Officer, these diagnostic tests were performed after August 10, 1982, and in the period of care found to be custodial by the Hearing Officer. This recommendation is, therefore, inconsistent with the finding of custodial care and the regulation limitation authorizing CHAMPUS cost-sharing only of prescription drugs and 1 hour of skilled nursing during a period of custodial care. Therefore, I must reject the Hearing Officer's recommendation to cost-share these charges as inconsistent with factual findings and applicable regulation authorities. I find the CT scan, EEG, and laboratory tests were performed during the provision of custodial care and are excluded from CHAMPUS cost-sharing on that basis.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to authorize CHAMPUS cost-sharing of inpatient care at Eastern State Hospital for April 29 through May 5, 1982, and at Sacred Heart Medical Center from August 1 through August 10, 1982, and of related professional charges during these periods as medically necessary inpatient care for an acute exacerbation of the patient's custodial condition. My decision is to deny CHAMPUS cost-sharing of inpatient care at these facilities from May 6 through June 22, 1982, and from August 11 through September 20, 1982, as well as the related professional charges during these periods, except for prescription drugs and 1 hour of skilled nursing services per day. Laboratory services, EEG, and the CT scan provided after August 10, 1982, are also denied. This decision is based on findings the care was custodial during the periods of hospitalization denied cost-sharing and exceeded the period of hospitalization necessary to stabilize the patient's acute exacerbation of the custodial condition. The appeal and the claims of the beneficiary are, therefore, partially denied and partially approved. As this decision denies cost-sharing of the physician services provided August 10 through September 20, 1982, the matter of potential recoupment of the cost-sharing of these

services is referred to the Director, OCHAMPUS, for consideration under the Federal Claims Collection Act. Issuance of this FINAL DECISION completes the administrative appeal process under DoD 6010.8-R, chapter X, and no further appeal is available.



William Mayer, M.D.

RECOMMENDED HEARING DECISION

Claim for Benefits Under the
Civilian Health & Medical
Program of the Uniformed Services
(CHAMPUS)

Beneficiary:

Sponsor:
SSN:

This is the recommended decision of CHAMPUS Hearing Officer Hanna M. Warren in the CHAMPUS appeal case file of and is authorized pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, Chapter X. The appealing party is the beneficiary as represented by her husband, a retired member of the United States Army. The appeal involves the denial of CHAMPUS cost-sharing for inpatient hospitalization and related care at Eastern State Hospital, Spokane, Washington, from April 29 through June 22, 1982 and inpatient hospitalization and related care at Sacred Heart Medical Center, Spokane, Washington, from August 1, 1982 through September 20, 1982 and the inpatient medical/psychiatric care rendered to the beneficiary while a patient at Sacred Heart Medical Center by Donald Woodke, M.D.

The hearing file of record has been reviewed along with the testimony given at the hearing and the arguments made by the sponsor and the attorney representing the appealing party. It is the OCHAMPUS position that the Revised Formal Review Decision, issued January 31, 1984, denying CHAMPUS cost-sharing for the inpatient hospitalization at Sacred Heart Medical Center, related medical care save for prescription drugs, and the related care by Dr. Woodke be upheld on the basis that the care was above the appropriate level to be medically necessary and in addition the CHAMPUS Regulation specifically excludes care that is custodial in nature. OCHAMPUS has subsequently taken the position one hour of skilled nursing care a day should be allowed.

It is also the OCHAMPUS position that the Formal Review Decision issued May 3, 1984 concerning the hospitalization at Eastern State Hospital be upheld and care from April 29 through May 5, 1982 be allowed as appropriate, medically necessary care, but that inpatient hospitalization and all related services from May 6, 1982 through June 22, 1982 be denied except for prescription drugs and one hour of skilled nursing care per day on the same basis as the denial described above for care at Sacred Heart Medical Center.

The Hearing Officer, after due consideration of the appeal record and the testimony, partially concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing but disagrees in part with the OCHAMPUS recommendation. The recommended decision of the Hearing Officer is to allow one week of the care rendered at Eastern State Hospital, and all charges for prescription drugs and one hour of skilled nursing care per day during the period of hospitalization found to be custodial. For the period of care at Sacred Heart Medical Center,

it is my recommended decision that the first ten days of hospitalization be allowed, along with the diagnostic tests, prescription drugs and one hour of skilled nursing care per day during the period of hospital care found to be custodial. Care provided by Dr. Woodke is recommended for coverage during this initial ten day period.

FACTUAL BACKGROUND

This sixty year old woman became extremely agitated at her home in Spokane on April 29, 1982 and the paramedics were called. They determined she needed to be hospitalized on a psychiatric ward and Sacred Heart Medical Center was called but no space was available, so she was taken by ambulance to Eastern State Hospital. Because the beneficiary would not voluntarily sign herself into the hospital, a court order was obtained so she could be held for treatment. The record is a little unclear about this but I believe that at the end of the court-ordered treatment period the patient voluntarily signed herself as an admission as May 18, 1982. She remained at Eastern State Hospital until June 22, 1982.

A claim was submitted for the care at Eastern State Hospital from April 29 through June 22, 1982 to the fiscal intermediary, Blue Cross of Washington and Alaska, in the amount of $5,037.29. The diagnosis given was Alzheimers, primary degenerative dementia, pre-senile onset with depression. The claim shows that $3,840.00 had been paid by Prudential Insurance Company, leaving a balance due of $1,597.29 (Exhibit 1, page 1). This entire amount was denied upon initial processing by the fiscal intermediary on the basis that the "services for the diagnosis shown on this claim are not allowed by the CHAMPUS program" (Exhibit 2, page 1). The beneficiary's husband then wrote to the fiscal intermediary and asked that the claim be reviewed because he felt they had not considered Alzheimers a disease. He submitted letters at that time from several doctors (Exhibit 3, page 1). The first was a letter from Roger W. Hedin, M.D., in San Rafael, California, who stated that the beneficiary had been a patient of his since 1965 and had some confusion and difficulty in functioning in 1974; later that year becoming increasingly forgetful and easily confused. He reported she was evaluated by a neurologist and neurosurgeon in 1976 and they both agreed on the diagnosis of Alzheimers disease at that time (Exhibit 3, page 2). The second letter was from Donald Woodke, M.D., who treated the beneficiary from August 1, through September 20, 1982 while she was at Sacred Heart Medical Center. He confirmed that she had Alzheimers disease and "the predicted course is one of eventual complete incapacitation within the next several years even though she is a relatively young person." He stated that her neurological consultation by Dr. James Lea excluded other processes that might allow them to expect a different prognosis (Exhibit 3, page 3). Dr. Bruce Amundson, M.D., also wrote stating that the patient was aflicted with Alzheimers disease and, at the time of writing the letter, was in a nursing home and he was attending her. He reported she was "disoriented to time, place and person and requiring mild to moderate doses of phenothiazines to control some of the associated symptoms of her disease. Consultation has been required by the psychiatric staff of the elderly services program of the community health center for management." (Exhibit 3, page 4).

The fiscal intermediary then wrote to the beneficiary's sponsor and said the above described letters from the three physicians had been provided to the Medical Review Staff of the fiscal intermediary but it was still their determination "that the documented diagnosis is excluded under the CHAMPUS program." (Exhibit 4, page 1). The sponsor then requested informal review (Exhibit 5). The Informal Review Decision letter from the fiscal intermediary clearly denies coverage for the care at Eastern State Hospital but the reasons are a little confusing. They quote a section of the Regulation which excludes "service and supplies related to minimal brain dysfunction (MBD), also sometimes called organic brain syndrome, hyperkenesis or learning disorder." They also referred to Chapter IV.B.1.f. of the CHAMPUS Regulation mandating that the supplied services must be directly related to a covered diagnosis and/or a definitive set of symptoms and also included the definition of medical necessity. The Reconsideration Decision regarding the Eastern State Hospital claim was issued April 15, 1983 (Exhibit 11), and gives the above same exclusions and limitations and definitions, apparently relying on the section excluding services related to minimal brain dysfunction, organic brain syndrone, hyperkenesis or learning disorder. A request for a formal OCHAMPUS review was then made by the attorney for the beneficiary and her sponsor and at the same time he asked for a formal review of the other two claims for hospitalization and psychiatric care at Sacred Heart Medical Center which will be discussed below.

OCHAMPUS conducted a case conference with their medical director after he had reviewed the file and he found that it was inappropriate to associate the non covered diagnosis, as the fiscal intermediary had done, with minimal brain dysfunctions. The medical director stated the correct issue in this case is "whether the inpatient care was custodial" (Exhibit 17).

Hospital records of the beneficiary's stay at Eastern State Hospital were requested on January 16, 1984 (Exhibit 25). History relating to the stay in Eastern State Hospital from April 29 through June 22, 1982 is contained in Exhibit 27. The preadmission referral information shows the presenting problems were, "disoriented x 2, combative, agitated, labile, shaky, refusing meds," and the suggested goal of hospitalization was to stabilize and return to husband (Exhibit 22, page 3). The discharge summary shows "of the multiple reasons for admission, the most pertinent was the hysterical-like state including running up and down hallways screaming" (Exhibit 27, page 5). It continues: "During the patient's one and four-fifths months of hospitalization there was very little response to medications and no significant degree of resolution of symptomatology." The discharge plan states she is to go to live with her husband and he has "a twenty-four hour licensed nurses aide to help him with patient management." It concludes: "Condition on release was essentially unimproved." The hospital records show a very disturbed woman and they speak consistently of increasingly confused and disoriented with weeping. She wandered considerably, fell occasionally, was very agitated, and at times combative. Because of her wandering behavior and tendency to fall, she appeared to frequently need restraints during this hospitalization. The progress notes written on the date of discharge show, "Patient is somewhat improved as compared to her status on admission. Will be in custody of a 24-hour CNA and her husband. Prognosis poor." The 3:15 p.m. discharge note

states that her husband and a nurses aide came to take her home. When I asked the beneficiary's husband about these notes he said he did not understand why they had written that because he never had a nurses aide or an LPN to assist him in taking care of his wife and that the young woman who was with him and who worked for him did not have this training. He also testified he felt his wife was improved at the end of this period of hospitalization and that she improved even more when she came home to stay.

The medical records regarding this claim, the letters from physicians who had treated the beneficiary and the claim form were sent to the American Psychiatric Association for psychiatric peer review before a Formal Review Decision was issued by OCHAMPUS. The peer review recomendation is contained in Exhibit 30 regarding the hospitalization at Eastern State Hospital. The peer reviewer states "There is no known treatment that will either reverse or arrest the progress of the disease," but goes on to say that a patient suffering from Alzheimers disease may show a variety of clinical pictures and "while one cannot expect any reversal or even arrest of the degenerative processes, various symptoms can be treated to, at least on a temporary basis, ameliorate the patient's disorder function. An effort to ameliorate the symptoms is certainly an appropriate intervention. Sometimes the organic process has been compounded by a mild, intercurrent illness, say with fever, or by a stressful emotional situation, poor hydration, nutrition, and so forth. Correction of any disturbance in these areas along with judicious use of appropriate medications may have a beneficial effect. Again, it must be stressed that this deals only with the symptomatic state and does not alter the underlying degenerative process." (page 1). In response to the question as to whether an appropriate level of care was inpatient hospitalization, the reviewer found:

> "Inpatient care was appropriate during the early part of the patient's treatment. She was highly agitated and disturbed needing close attention and supervision. A short period of evaluation and an effort to resolve any complicating factors would be reasonable. It is difficult to put an exact time period on that. In general, I would say that a period of a week to study the patient for any complications and attempt at stabilization would be reasonable. Because of the difficulties in the problems it might very well take another week to arrange (????) planning to another facility or to a home care setting that would be appropriate."

In response to the question as to whether care could have been provided at a lower level facility or outpatient basis, the reviewer found:

> "Based on the record, it appears doubtful that this patient could have been handled in a nursing home or a home setting even with around the clock nursing during the period of the hospitalization. Most nursing homes--even skilled nursing homes--would not have accepted a patient who is this disturbed."

The reviewer was asked if the care could reasonably have been provided in the home setting during the period of her hospitalization and the reviewer found that she was ultimately discharged to her home with round the clock care and the staff was extremely doubtful that she could be handled at home. A question was also asked as to whether the institutionalization was to provide a substitute home or because it was medically necessary for the beneficiary to be in the institution and the reviewer answered:

> "In my judgment, it was medically necessary for the beneficiary to be in the institution because of the severity of her disturbed behavior. It was necessary to place her in restraint on a number of occasions as already indicated. A brief period at least of assessment and an attempt of stabilization through medication would be justified. Beyond that the treatment becomes esentially custodial."

The reviewer found that her disability would continue for the rest of her life and the progression had initially been rather slow, so it might be for an extended period of time. The reviewer also found she required a protected and controlled environment because of her extreme agitation and required assistance to support the essentials of daily living because of the severe deterioration and loss of mental capacity. The reviewer was asked if the patient was under "active and specific medical treatment which could have been expected to reduce the disability to the extent necessary to enable her to function outside a protected, monitored and/or controlled environment" and he answered:

> "At the outset, the assessment of the patient and evaluation to see if there were a problem that might be corrected would constitute at least a specific medical evaluation that might lead to a reduction in the disability. As noted in my background statement, Lecithin has not been generally established as efficacious although it is certainly a medication that is occasionally tried with such patients."

The reviewer also found that she would require more than one hour of skilled nursing care per day--really needing around-the clock monitoring and periodic restraint and some form of sedation. He also found that, "Certainly her symptomatic behavior can be viewed as a complication and one that would be worthy of at least diagnostic review as already described." In answer to the question, "Would any part of the hospitalization be medically required for treatment of complications of the Alzheimers Disease", the reviewer answered:

> "To the degree that one interprets the patient's agitation and generally violent behavior as a complication of Alzheimers Disease the hospitalization was medically necessary. It perhaps is somewhat of a somantic distinction but one can interpret that simply as one of the manifestations of the illness. The patient clearly would have needed very close

supervision either in a nursing home or in a home setting where nursing care was made available. Patients with severe organic deterioration can be well handled in such settings unless they become violent which does occur episodically. It is quite appropriate under those circumstances to attempt stabilization through a relatively brief hospitalization. Again, it is stressed that this is not a hospitalization aimed at altering the underlying course of the illness. We have no evidence of any kind of specific complications such as an infection which might have lead to fever, which in turn could have caused such a disturbance or any of the other conditions that were described. In other words no complicating physical condition is described in the record."

A case conference regarding this appeal was held with the OCHAMPUS Medical Director, who is a psychiatrist. This is contained in Exhibit 31 and shows the recommendation of the American Psychiatric Association Peer Review, which concerned the hospitalization at Eastern State Hospital from April 29 through June 22 was reviewed along with the Colorado Foundation for Medical Care Review, which concerned the hospitalization and related care at Sacred Heart Medical Center from August 1 through September 20, 1982. The case conference report appears to address itself almost totally to the APA peer review and the hospitalization at Eastern State Hospital, so I will discuss Dr. Rodriquez' recommendation at this time. The Medical Director was asked if the inpatient care was the appropriate level of care and he stated that he agreed with the APA peer reviewer that one week "would be appropriate for an initial evaluation of a patient with Alzheimers Disease where there were no significant complications, such as with this patient." Following that initial evaluation period she did not require the acute level of care. "In fact, the normal procedure would be to transfer such a patient to a skilled nursing facility or custodial care facility...basically she needed to be in a custodial care facility with structured and supervised 24 hour care. The predominant service was one of providing assistance in the activities of daily living, i.e. assistance with hygiene and feeding, bathing, sleeping and other daily tasks. The only thing actually requiring skilled nursing care, i.e., care requiring a license and specific training of a nurse, would be the administration of medication." Dr. Rodriguez continued, "I realize that granting a one week stay for initial or follow-up evaluation at the acute care level is extremely liberal, since the patient already had a presumptive diagnosis of Alzheimers Disease. However, we have to consider that the patient had an acute episode of irriational behavior that may have been due to something other than Alzheimers Disease. For example, it could have been due to a toxic reaction to a medication or to another type of primary medical condition. Therefore, a one-week inpatient evaluation of this abrupt change in behavior which followed a relatively progressive and stable course of behavior was appropriate in order to determine that there were no other causes. In fact, what this probably represented was a more sudden deterioration of her Alzheimers condition and that is not an uncommon kind of complication. Therefore, I would agree that a one-week medically oriented evaluation would be considered appropriate. However, this patient was not a candidate for psychotherapy or for longer term

intensive medical treatments or evaluations." He stated that any care after a week could have been provided in a custodial care facility and the type of care she requried was at a higher level than "what could generally be provided in the home environment unless there were an unusual level of supervisory ability." He found the first week of hospitalization to be medically necessary. Dr. Rodriguez appears to agree with the APA peer reviewer that the disease itself is progressive and not curable but that "occasionally certain symptoms or expressions of the disorder brain functions such as agressiveness which is due to disorientation or malnutrition or the toxic effects of drugs can symptomatically be treated." He goes on to say that the same person who has previously responded to treatment might not be responsive at another time, "Therefore, when we talk of treating the symptoms we are really only talking about a temporary intervention that is quite variable in response and only a symptomatic stabilization." He found that she would indefinitely require a protected, monitored and controlled environment and required assistance to support the essentials of daily living. In response to the question, "Was the patient under active and specific medical treatment which could have been expected to reduce the disability to the extent necessary to enable her to function outside of a protected, monitored, and/or controlled environment", Dr. Rodriguez answered as follows:

> "The answer is no. The only active treatments provided during that one week of hospitalization were to allow her to function in a less intensively monitored controlled environment. I would say that, at best, any period of hospitalzation for an acute medical condition which was a complication of or incidental to the primary condition of Alzheimers disease would only allow the person to function at their usual level, which would be at the custodial care level. The active treatment provided such as nursing care in a custodial care facility and medication administration could justify a limited amount of skilled nursing care."

The reviewer found she did require one hour of skilled nursing care and in response to the questions as to whether the admission was for diagnostic purposes or treatment of complications of the patient's primary condition and medically required for treatment of complications of Alzheimers Disease, the Medical Director responded that, one week at an acute level is appropriate and medically necessary for evaluation purposes and "part of the admission was for diagnosis and part was for treatment, since there was a presumption that the patient might have been treatable over a period of time and responsive. In fact, a period of one week, is certainly more than sufficient time to ascertain whether the sole condition being evaluated was Alzheimers Disease and whether the change in behavior and function was the result of the Alzheimers Disease and not a medical condition."

A Formal Review Decision regarding the Eastern State Hospital care was issued May 3, 1984 and that decision allowed services and supplies related to the inpatient hospital care from April 29 through May 5, 1982, as this care was found to be medically necessary and appropriate for diagnostic evaluation and treatment for stabilization. The inpatient care from May 6 to June 22 was

denied as it was found to be custodial care and not provided at the appropriate level required for the patient's condition. One hour of skilled nursing care and prescription drugs were allowed during the period May 6 to June 22, 1982 as medically necessary.

The beneficiary's husband testified that at the time of her discharge from Eastern State Hospital on June 22, 1982, she came home to live with him in their trailer home in Spokane, Washington. He said he had a young woman come in to assist him with the house work and occasionally stay with his wife when he was gone, but that otherwise she was at home and able to function in a reasonably normal way. She could dress herself, feed herself and took care of her toilet functions. They went out to dinner, went on walks, and went to the swimming pool at the mobile home park where they lived, went to their daughter's house for dinner, slept well with no restraint of any kind, and it was her husband's testimony that she was essentially the same at home as before she had been hospitalized.

At approximately the end of the fifth week at home, her husband testified he could see something was the matter. She was becoming very agitated, wouldn't go to bed, and was very restless. At that time the beneficiary was seen by Dr. Sands, a psychiatrist at the Community Mental Health Center, who evaluated her and recommended hospitalization at Sacred Heart Medical Center. Dr. Sands wrote a letter for the purposes of this appeal which is Exhibit 19, page 135. I believe testimony at the hearing would indicate that the date of his first evaluation for is in error and she was first evaluated by him on August 1, 1982, after which she was hospitalized.

Although the beneficiary was admitted to Sacred Heart Medical Center on August 1, 1982 on an emergency basis she was transported by automobile for this admission rather than by ambulance. Donald Woodke, M.D., who is a psychiatrist, was her attending physician and he saw her the day after her admisson. The history and physical shows a very limited physical examination because the patient was fighting most of the time. The same thing occurred at Eastern State hospital when the physical examination was attempted six different times and the patient fought and resisted each time. Dr. Woodke stated in his exam that when he attempted to interview the patient, "she was crying, moaning and I could not understand more than a word or two of what she was saying." She was able to ambulate, although it had been difficult earlier in the day because it appeared that on admission she was started on a very low dosage of Mellaril. In the history and physical conclusion, Dr. Woodke says it appears the patient suffers from Alzheimers Disease and states, "appears that she is unquestionably demented, probably very disoriented for place and time. I shall try Haldol and hospitalization of a couple of weeks may be anticipated. Hopefully, with the opportunity of returning her to outpatient care somewhat other than having her go to Eastern State Hospital." (Exhibit 19, page 9).

A consultation was done on August 10, 1982 by James Lea, M.D., who is a neurologist. In this consultation the assessment is as follows: "This patient demonstrates a progressive intellectual deterioration over approximately 10 years beginning around age 49. Given this young age it is certainly mandatory to rule out any treatable causes of dementia. To this end a B-12 level, CBA with ERS, thyroid battery and serum protein electrophoresis have been ordered.

A CT Scan should be obtained with and without contrast to rule out mass lesion or chronic subdural hemotoma. An electroencephalogram may also be of use as well. Following these tests if they are normal a lumbar puncture should be performed to look for chronic infectious process (Exhibit 19, page 14). Clinical immunology was done on August 11, 1982 and was within normal limits (Exhibit 19, page 72). The CT head scan with and without contrasts was done on August 11, 1982 and the summary states, "Findings suspicious for mild atrophy. Otherwise negative CR head scan." (Exhibit 19, page 73). An electroencephalogram was performed on August 11, 1982 and interpretation states, "This is an abnormal electroencephalogram demonstrating moderate diffuse slowing and a generalized distribution. These findings are compatible with a toxic or metabolic encephalopathy or a structural process that effects both cerebral hemispheres in a diffused fashion." (Exhibit 19, page 74). A lumbar puncture was performed on August 13, 1982. This appears to have been unremarkable and the test for cryptococcus Antigen was negative (Exhibit 19, page 71). The neurologist wrote several notes in the chart and on August 18, 1982 Dr. Woodke wrote "neurological evaluation appears to be complete" (Exhibit 19, page 32).

An examination of the patient's chart shows that her behavior in the hospital was very unpredictable. One day she would be very agitated and need almost total care for eating, toileting, etc., and another day the nursing notes would say patient much more cheerful and less confused. It was necessary for her to be assisted in eating at times, in taking care of her excretory functions and to restrain her to prevent her wandering around. This problem seems particularly acute as far as going to bed and staying in bed without restraints. The record clearly indicates a very confused, disoriented and disturbed woman. Dr. Woodke wrote daily notes and would either increase, decrease or maintain the patient's medication based upon her condition. I think it is fair to conclude that when the medication was increased the patient became less restless but tended to wander more and suffered a problem with drooling and other disorientation. When the medication was decreased she was more alert and responsive but also more agitated, weepy and more combative (Exhibit 19, page 59).

The discharge summary (Exhibit 19, page 6) discusses the neurological consultation and the exclusion of other neurological conditions. The results of the tests described above were given and all were essentially negative. She was discharged on Haldol, Xanax, Cogentin, Colace, and Mellaril. Dr. Woodke stated: "Her behavior indicated severe dementia and varied between apparent euphoria to tearful whining and some combativeness particularly when medications were reduced." He reported that she was discharged to a nursing home and was to be seen by Dr. Bruce Amundson. He found "The patient was totally oblivious in my estimation of where she was located and the expectation that medication would do other than comfort her would in my estimation be unreasonable." It was his hope she could continue to live in a nursing home but he had reservations as to how long this would be possible because of her need for very close nursing attention. He stated in the discharge diagnosis, "It is possible she eventually will need to be admitted to Eastern State Hospital."

A bill was submitted for this hospitalization in the amount of $12,099.95; $3600.00 of this amount was paid by Prudential Insurance Company, leaving a balance of $8,443.85. A statement was submitted by Dr. Woodke as follows: August 2, 1982, Sacred Heart Medical Center admission, physical and psychiatric evaluation, $120.00; August 3, 1982 through 9/20/82, 49 consecutive daily one-half hour follow up management and psychotherapy sessions at $44.00 each, $2,156.00; for a total charge of $2,276.00. Dr. Woodke's claim was initially allowed by the fiscal intermediary at $2,246.00, and with a cost-share amount of $561.50, CHAMPUS paid $1,684.50 (Exhibit 2, page 2).

The claim from Sacred Heart Medical Center was denied by the fiscal intermediary (Exhibit 2, page 3) and the reason given again was services for this diagnosis were not allowed. The subsequent development of this claim essentially follows what was described above for the Eastern State Hospital claim. The beneficiary's husband wrote and sent letters stating the diagnosis was Alzheimers Disease. The fiscal itermediary wrote back stating that Alzheimers Disease was not a covered diagnosis (Exhibit 9, page 1). When it was determined that Dr. Woodke had been paid the hospital wrote and asked the fiscal intermediary to reconsider their payment (Exhibit 10, page 1). The fiscal intermediary responded that Dr. Woodke's claim had been paid in error and asked the beneficiary's husband to refund the payment of $1,684.50 because the services were for a non covered diagnosis (Exhibit 12, page 1). Upon informal review the fiscal intermediary again discussed exclusion of minimal brain dysfunction, organic syndrome, etc., and medically necessary (Exhibit 13, page 1). Formal Review was requested by Mr. Ruhl for all three claims. At that point OCHAMPUS requested the entire inpatient hospital record for the period the patient was in Sacred Heart Medical Center (Exhibit 18, page 1) and this was received. This entire medical record along with letters from Doctors Amundson, Hedin, Sands and Woodke were sent to the Colorado Foundation for Medical Care for peer review (Exhibit 20, page 1).

The peer review summary is contained in Exhibit 21. The peer reviewers found that, "An acute care hospital was not the appropriate level of care to evaluate the patient's intellectual deterioration and adjust medications. In addition, it does not require seven weeks to accomplish this objective." In response to the question as to whether the care have been provided at a lower level on a outpatient basis, the peer reviewers concluded:

> "The patient's history showed she required protective and supportive care before, during and after the hospital stay. In addition the patient had been hospitalized just two months earlier for the same condition. It is not clear why she needed to be hospitalized again. She did not need to be hospitalized for a mental evaluation, medication adjustment, or to find long-term care placement. She required custodial care and was eventually placed in a senior citizens nursing home. We see no reason why her care after August 1, 1982 required anything higher than a nursing home for custodial care."

The reviewers found she could not have been cared for at home, even though the original expectation of her family was that would happen. They also felt the hospitalization "essentially served as a transition for the patient between home care which was not going well, and eventual nursing home placement." They again reiterated it was not necessary for the patient to be hospitalized for seven weeks, that she could have gone from her home to a nursing home without a hospital stay, "particularly in view of her recent hospitalization just two months prior." They stated that the patient's disability was expected to continue and be prolonged, that she required a protected, monitored and/or controlled environment to ensure her safety and that "the nursing notes state the patient required total assistance with activities of daily living." In response to the question as to whether the patient was under active and specific medical treatment which could have been expected to reduce the disability to the extent necessary to enable her to function outside a protected, monitored and/or controlled environment, the reviewers answered as follows: "No. The patient's treatment was protective and supportive care which was not expected to reduce the disability to permit her to function outside a protected, monitored and controlled environment. There is no active, disability reducing treatment for Alzheimers Disease." In response to the final question as to whether the patient required at least one hour of skilled nursing care per day, the reviewers answered no, that she required only personal care and supervision of medication which do not constitute skilled nursing care.

A Formal Review Decision was issued on November 30, 1983 and a revised Decision on January 31, 1984 which denied all CHAMPUS cost-sharing for the hospitalization and related medical care at Sacred Heart Medical Center from August 1 through Septebmer 20, 1982 and found that the only services and supplies which could be cost-shared for that episode of care were prescription drugs. In addition, Dr. Woodke's claim for services during the same period was denied. A request for hearing on all three claims was submitted by Mr. Ruhl and prior to the hearing, a Statement of OCHAMPUS Position was submitted (page 39). This statement recommended upholding the original denial of care on the basis that it was custodial care and was above the appropriate level of care required to provide medically necessary treatment, but the position of OCHAMPUS had changed regarding the nursing care. It was the OCHAMPUS position at the hearing that one hour of skilled nursing care per day should be allowed during the period of hospitalization at Sacred Heart Medical Center based upon the recommendation from the OCHAMPUS Medical Director who stated: "Due to the nature of the patient's condition, the technical proficiency and scientific skill of an RN were required to assess the patient's response to various medications being administered" (Exhibit 39).

A hearing was held July 13, 1984 at the U.S. Courthouse, Spokane, Washington, before OCHAMPUS Hearing Officer, Hanna M. Warren; the sponsor; his attorney, Roger L. Ruhl; and Donald Woodke, M.D.. Steven G. Plichta attended the hearing representing OCHAMPUS.

ISSUES AND FINDINGS OF FACT

The primary issue in dispute is whether the care provided the appealing party was custodial care as described in DoD 6010.8-R, Chapter IV.E.12 and as such, was also above the appropriate level of care to provide medically necessary treatment for the diagnosis. Secondary issues that will be addressed include the issue of coverage by private insurance companies, representations made to the beneficiary, erroneous payment/recoupment and burden of evidence.

Regulation DoD 6010.8-R is issued under the authority of and in accordance with Chapter 55, Title X, United States Code. It establishes uniform policy for the world-wide operation of the Civilian Health and Medical Program of the Uniformed services (CHAMPUS). Chapter IV of the Regulation defines basic program benefits and paragraph A-1 provides in pertinent part 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, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals or other authorized institutional providers, physicians and other authorized individual professional providers..."

Medically necessary is defined in Chapter 2(B)104 as follows: "Medically necessary means the level of services and supplies (i.e., frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury. Medically necessary includes concept of appropriate medical care."

"Appropriate medical care" is further defined as that care rendered in keeping with the generally accepted norm for medical practice in the United States by an authorized profesional provider and "The medical environment in which medical services are performed is at the level adequate to provide the required medical care". (Chapter II, p. 14).

CHAMPUS benefits may be extended for covered services and supplies provided by a hospital or other authorized institutional provider, subject to any applicable definitions, conditions, limitations, exceptions and/or exclusions. (chapter IV(B)(1)). Chapter IV(1)(a) provides as follows: "For purposes of inpatient care, the level of institutional care for which basic program benefits may be extended must be at the appropirate level required to provide the medically necessary treatment...".

This restriction is repeated in the specific exclusions of IV(G) which provides, "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: (emphasis theirs)

"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.

"7. Custodial care. Custodial care regardless of where rendered.

At the conclusion of the specific exclusions is the following note: "The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion."

There are certain medical issues which are covered in the CHAMPUS Regulation in the Section titled "Special Benefit Information", (Chapter IV(E)). These are special circumstances and/or limitations which "impact the extension of benefits and which require special emphasis and explanation." The section relevant to this hearing is as follows:

Chapter IV(E)(12). Custodial Care. The statute under which CHAMPUS operates specifically excludes custodial care. This is a very difficult area to administer. Further, many beneficiaries (and sponsors) misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the 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.

a. Definition of Custodial Care. Custodial care is defined to mean that care rendered to a patient (1) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored and/or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) 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., L.P.N., or L.V.N.

b. Kinds of Conditions that Can Result in Custodial Care. 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 that is controlling but whether the care being rendered falls within the definition of custodial care.

c. Benefits Available in Connection with a Custodial Care Case. CHAMPUS benefits are not available for services and/or supplies related to a custodial care case (including the supervisory physician's care), with the following specific exceptions:

(1) Prescription Drugs. Benefits are payable for otherwise covered prescription drugs, even if prescried 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.

(3) Payment for Prescription Drugs and Limited Skilled Nursing Services Does notAffect Custodial Care Determination. The fact that CHAMPUS extends benefits for prescription drugs and limited skilled nursing services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

d. Beneficiary Receiving Custodial Care: Admission to a Hospital. CHAMPUS benefits may be extended for otherwise covered services and/or supplies directly related to a medically necessary admission to an acute care general or special hospital, under the following circumstances:

(1) Presence of Another Condition. When a beneficiary receiving custodial care requires hospitalization for the treatment of a condition other than the condition for which he or she is receiving custodial care (an example might be a broken leg as a result of a fall); or

(2) Acute Exacerbation of the Condition for Which Custodial Care is Being Received. When there is an acute exacerbation of the condition for which custodial care is being received which requires active inpatient treatment which is otherwise covered.

Skilled nursing care is defined in DoD 6010.8-R, Chapter II,B.161, 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 results. 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 supervision." This same Chapter defines essentials of daily living in B.67 as follows: "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 bedsores); 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 Federal law authorizing CHAMPUS benefits requires benefits be paid only for services determined to be medically necessary, which is by definition rendered at the appropriate level of care. In addition, custodial care is specifically excluded from CHAMPUS cost-sharing (10 USC 1077). The CHAMPUS Regulation discussed above implements this statutory exclusion in greater detail. As the regulatory provision states, this is a very difficult area to administer and a difficult area in which to make decisions as a Hearing Officer. The record is abundantly clear that the beneficiary in this case needed care as she was very disturbed, agitated and confused. I believe the main issue that must be decided by me is whether the care met the regulatory definition of custodial care and if it does, it does not mean the care was not necessary but only that it was the type of care for which CHAMPUS benefits cannot be extended.

My review of the record leads me to conclude there is really no dispute involving the first three parts of the definition of custodial care. The beneficiary was clearly disabled and her disability was expected to continue and be prolonged. I believe it is important to emphasize the distinction made by the APA Peer Reviewer and also made very clear several times during the hearing by Dr. Woodke. The underlying condition suffered by this beneficiary, Alzheimers Disease or presenile dementia, is a disability which is expected to continue and to be prolonged. Three peer reviewers found this to be the case as did the OCHAMPUS Medical Director, and Dr. Woodke testified at the hearing this was true. The same facts are true for her need for a protected, monitored and controlled environment and for assistance to support the essentials of daily living. That these criteria were met is not an issue in dispute except for statements in Mr. Ruhl's closing argument. At that time he said three of the criteria were in dispute; that she did not need a protected and controlled environment nor help for the essentials of daily living. I think there is some confusion about what period of time we are talking about. Whether these criteria applied when she was not in the hospital is not at issue in this case. The only period of time for which we are discussing whether she needed a protected environment and help in the essentials of daily living is the period of the two hospitalizations. I think during that period of time Mr. Ruhl would agree these criteria were met. The fourth criteria is the one over which there is a dispute in this hearing. For approximately the three month period of hospitalization at these two hospitals (except for the first week at Eastern State Hospital) it is the OCHAMPUS position that the beneficiary was not under active and specific medical/surgical and/or psychiatric treatment which would reduce her disability to the extent necessary to enable her to function outside a protected, monitored and/or controlled environment. I concur with the OCHAMPUS determination in part, and disagree in part, based upon the material presented at the hearing.

The stay at Eastern State Hospital will not be discussed in great detail by me because I believe the APA peer reviewers' discussion of this care contained in Exhibit 30 is such a clear presentation of the issues in this hearing that I essentially adopt his rationale, which I find to be supported by the record and the testimony from Dr. Woodke regarding Alzheimers Disease and its progression

and complications. At the hearing the sponsor testified he and his wife had been staying at their daughter's home in Spokane, Washington and all of a sudden, out of a clear blue sky his wife just "cracked up". This abrupt change in her behavior is described in the record and amply supported by testimony at the hearing. For that reason, I agree with Dr. Gibson that her "symptomatic behavior can be viewed as a complication and one that would be worthy at least of a diagnostic review as already described." I also agree with the OCHAMPUS position that after the first week the record does not show any medical care rendered which would necessitate continued hospitalization or care that would be expected to reduce her disability. It consists almost entirely of protective care. Within the first week of her admission the beneficiary was transferred from what would appear to be a more intensive care ward to a regular ward, 1N3. The physician/patient treatment orders from Eastern State Hospital in the file stop with the 24th of May and, even if part are missing, the orders that are in the file for the initial period of hospitalization are mostly connected with routine manners and do not show any change or attempt to adjust the medication. The progress notes during this period show the physician is concerned about his inability to conduct a physical exam but do not show that any other medical evaluation was being made.

As regards the care at Sacred Heart Medical Center, I agree in part with the CHAMPUS determination but, based upon the material at the hearing, I find that conditions justified a ten-day period of hospitalization for diagnostic and stabilization purposes. Dr. Woodke in his testimony at the hearing stated that all patients with Alzheimers Disease are not the same in that deterioration occurs at different rates. The brain cells are gone so the disease process will not reverse and will become progressively more severe but frequently the symptoms wax and wane. There are periods during which the condition may improve or conversely the symptoms may become acute. This is also described in the APA peer review: "A patient with a degenerative disease such as Alzheimers Disease may show a variety of clinical pictures ranging anywhere from the simple memory loss and a quiet withdrawal to more episodic disturbed behavior or even hallucinations. The symptomatic behaviors constitute the psychological interplay in the progressive organic damage. While one cannot expect any reversal or even arrest the degenerative processes, these various symptoms can be treated to at least on a temporary basis, ameliorate the patient's disorder function. An effort to ameliorate the symptoms is certainly an appropriate intervention." He concludes this discussion by saying, "Again, it must be stressed that this deals only with the symptomatic state and does not alter the underlying degenerative process."

Although this review concerned the beneficiary's hospitalization at Eastern State Hospital, I believe the testimony at the hearing indicates the same intervention was appropriate at Sacred Heart Medical Center. The beneficiary's husband testified at the hearing that, although the patient had suffered memory loss and confusion in 1974 and in 1976 had a neurological evaluation and a diagnosis of Alzheimers Disease, she functioned rather normally until just prior to the period we are dealing with in this hearing. He stated she had not received any medical care until the episode on the train just prior to the hospitalization at Eastern State Hospital. The testimony showed that up until the end of April, 1982, the patient's condition did not meet the definitions of custodial care in that she did not need a protected or controlled environment

nor help with the essentials of daily living. It appeared to be more simple memory loss and quiet withdrawal as described by Dr. Gibson in the peer review. Their daughter lived in Spokane, Washington and wanted them to move from their home in California to Spokane after the sponsor's retirement in order to be close to her. He stated they came up to look the area over and visit their daughter and on their way back to California, his wife became extremely upset. They had to take her off the train and have her admitted to a hospital in Mt. Shasta, California, where they sedated her and she remained overnight. The next morning she was discharged and some friends drove up to meet them and take them home. They closed their home, sold it and when they returned to Spokane the patient flew for that trip without incident. After they arrived in Spokane, they were staying at their daughter's home when his wife became very acutely disturbed as discussed above, which resulted in her admission to Eastern State Hospital. At the end of that hospitalization, she returned home and stayed in their new trailer home with her husband and a young woman he had hired to occasionally come and help him. This seems hard for someone examining the hearing file to believe in that the notes at Eastern State Hospital described this patient as extremely disturbed, agitated and difficult and a great concern that her husband would not be able to manage her. Both the nursing, social worker, and physicians' notes at Eastern State and Sacred Heart state the husband is extremely supportive and motivated to have his wife return home but that he is unrealistic regarding her ability to function in a home setting and his ability to care for her. He admitted at the hearing that because she had done so well at home, and because of the slow progression of her disease, he desperately wanted to do everything possible to see if she could remain at home and be cared for there. He felt she was so much more comfortable and less confused at home. There are several places in the record where it speaks to a change in environment sometimes being a precipatating cause for increase in symptoms or deterioration in patients with Alzheimers Disease condition and it seems logical to assume that to an extent this was what was operating at the time in question because her condition deteriorated so rapidly compared to what is in her prior history and described in her husband's testimony.

When her condition deteriorated in August, Dr. Sands recommended to the beneficiary's husband that she be hospitalized at Sacred Heart General Hospital so a real medical/psychiatric workup could be done on her to determine if there were any medical reasons for the deterioration in her condition on arrival in Washington. It was also Dr. Woodke's testimony at the hearing there was absolutely no way this patient at the time of her admission could have been treated in a nursing home because she was much too agitated and disturbed until she became stabilized on her medication. At the time of her admission the history and physical done by Dr. Woodke shows that he anticipated two weeks of hospitalization to adjust her medication. It was his testimony at the hearing that he felt she needed to be hospitalized until approximately the end of the fifth week and he agreed that probably during the last two weeks extraordinary efforts were tried in the hospital because her husband was so supportive and so determined that she return home to live. He said this support encouraged them to try absolutely everything to make this possible.

My examination of the medical record, though, does not support Dr. Woodke's position there was some change at the end of the fifth week. The medical records from the hospital show that medication changes were attempted but the progress notes and nursing notes show her condition remained essentially unchanged. Many times during the course of her hospitalization there are notes regarding discussion of her discharge and the discharge date kept getting set up, but there is no clear evidence in the record as to a reason for this. Both the beneficiary's husband and Dr. Woodke testified that in retrospect it was clear the treatment was not going to result in her ability to live in an unprotected environment, but they did not know that at the time she was being treated. It is always difficult to look back and try and place yourself in the situation at the time the services were rendered because hindsight does make the care look more custodial since we know the eventual placement and subsequent course. Since the testimony at the hearing showed, and the record reflects this, that the patient had been under no active specific medical treatment up to the time she moved to Washington and it had been six years since a presumptive diagnosis of Alzheimers Disease had been made, coupled with the severe and sudden deterioration in her condition, I believe it is reasonable to expect that some stabilization of her condition might be achieved and a diagnostic workup was medically necessary to eliminate any other causes either for her condition or her acute deterioration. Although I have found that just her extremely agitated, combative, confused condition made the initial week of care at Eastern State Hospital medically necessary and not custodial care, I also find that a neurological/psychiatric workup was medically necessary and not custodial care at Sacred Heart hospital. For that reason, I will allow the neurological consult, the costs of the tests and the first ten days of care. Although the neurological workup was not started until the 10th of August and took approximately one week, there is no indication as to why it was not started during the first week of her hospitalization. Although I recommend allowing the workup, I am not going to allow until the 18th of August in order to do it. Because she had been able to go home and live and because this was such an extreme and acute deterioration in her condition, I believe it was reasonable to expect that the treatment and the workup being rendered to her as a diagnostic, evaluative, stabilization time could reasonably at that point have been expected to lead to her ability to function outside of a controlled environment, i.e., at home. Just because it did not would lead one to conclude the entire period of care was custodial, meeting all four of the criteria, but testimony at the hearing has convinced me that was not the case at the time the services were rendered. Beyond that initial ten days, though, I do not believe the care provided to the beneficiary was provided at the appropriate level to be medically necessary for her condition and I also believe it was not reasonable to expect that it would result in her being able to function in a less controlled environment.

Dr. Amundson, who is now treating the beneficiary, wrote that the patient had been cared for at home between hospitalizations and that it is only in retrospect that it is easy to conclude she was not under active and specific treatment which would reasonably allow her to return to the home setting. But even he questioned the length of inpatient hospital care (Exhibit 28, page 2) given the beneficiary's diagnosis and condition.

The doctor treating the patient and her husband made the determination she should remain in an acute hospital facility and the decision I make is not whether she should have stayed in the hospital, but only whether benefits will be provided under the CHAMPUS program for that hospitalization. I am not questioning the decision to continue acute care hospitalization, given the family circumstances of the patient, but my decision as to program benefits must be based upon the applicable law and regulation rather than personal circumstances. The evidence in the record does not support the finding that the care rendered after a ten-day diagnostic/stabilization period in the hospital was other than custodial, which is a level of care that is certainly appropriate in some circumstances, but for which CHAMPUS benefits are not available based on a specific statutory and regulatory exclusion.

As to the Eastern State Hospital care, the peer reviewer and the medical director both felt that one week was an appropriate length of time for inpatient care for diagnostic stabilization. I have considered the peer review of the two reviewers of the hospitalization at Sacred Heart Medical Center and realize they found the entire stay to be custodial care as a transition period from the home to the nursing home. In my opinion the testimony at the hearing enlarges the record which was available and also would note that neither of those reviewers was a neurologist or psychiatrist, as was the APA peer reviewer on whose discussion of the dynamics of Alzheimers Disease I have primarily relied. I realize, of course, that he was discussing the first hospitalization, but I believe testimony at the hearing makes his discussion appropriate not only to her initial hospitalization but as to what one reasonably could expect as to the second hospitalization. Dr. Woodke testified at the hearing that most patients with Alzheimers Disease are seen by psychiatrists or neurologists because other specialties do not have that much experience dealing with them. The reason for this is they are usually stabilized on psychotropic drugs and psychiatrists and neurologists have much more experience and competency in dealing with these drugs. The report of the Medical Director states that he reviewed both periods of care and both peer reviews. He does not distinguish in his report the period of time he is talking about but he, too, seems to agree basically with the APA peer reviewer's position and comments.

I have also considered the provisions of Chapter IV.E.12.d. providing benefits for otherwise covered services or supplies directly related to a medically necessary admission to an acute care general hospital if there is an acute exacerbation of the condition for which custodial care is being received which requires active inpatient treatment. Clearly there was an acute exacerbation of the beneficiary's progressive degenerative disease, but with the initial hospitalization I do not find this section applicable because the patient was not receiving custodial care prior to that admission. The second hospitalization comes closer because she appeared much more limited during the five weeks at home, even though it was her husband's testimony she required little care and assistance. Although there are some aspects in this case of the situation this section was meant to cover, it is my decision that the rapid and sudden deterioration shown by the beneficiary more appropriately required medically necessary diagnostic/stabilization intervention as discused by Dr. Gibson in his peer review explanation of the dynamics of Alzheimers disease.

The regulatory provisions regarding custodial care provide that "an occasional skilled nursing service may be required" and if needed can be allowed for one hour per day even if the rest of the care is found to be custodial. Although the Colorado Foundation for Medical Care reviewers found there was no necessity for skilled nursing services, Dr. Gibson stated the patient would require considerably more than one hour. Dr. Rodriquez agreed with that: "The professional expertise of an R.N. was required to properly observe responses in order for the attending physician to be accurately apprised of the effect of changes in the patient's medication (Exhibit 39). Dr. Woodke testified that the patient required constant monitoring by skilled psychiatric nurses because of her combative behavior and need to monitor the medication changes. The evidence shows a need for skilled nursing services and pursuant to the regulation, one hour per day may be cost-shared dring the period August 11 through September 20, 1982.

I therefore find as regards the Sacred Heart Medical Center hospitalization benefits should be allowed for hospital care from August 1 through August 10, 1982, the $321.25 charge for the lab work, the $111.00 for the EEG, and the $274.00 charge for the CT scan and one hour of skilled nursing care per day from August 11 through September 20, 1982. In addition, the Regulation provides that prescription drugs will be covered even though the care is found to be custodial so pursuant to that Regulation the entire $620.55 for drugs should be cost-shared by CHAMPUS.

RELATED CARE

Since I have found the care provided at Sacred Heart Medical Center after the first ten days to be custodial care under the CHAMPUS definition of care, the Regulation specifically provides that all services and supplies including the supervisory physician's care are also excluded. The services of Dr. Woodke from August 2nd (when he first saw her) through August 10th would be covered, but should be denied after that period as services related to a non-covered condition and specifically excluded under the custodial care provisions of the CHAMPUS Regulation.

SECONDARY ISSUES

Coverage by Private Insurance Companies. At the hearing the sponsor made the argument that he had insurance coverage through the Prudential Insurance Company and they paid for his wife's care without any questions asked; implying that CHAMPUS should also pay for the care. CHAMPUS is not an insurance program, but is a benefits program. Coverage provided under private insurance policies for which benefits have been bargained and known before the policy is obtained is not, nor can it be, the basis for my decision. CHAMPUS is an "at risk" program whereby the beneficiary obtains care and submits an after the fact claim for processing by the government or its fiscal intermediaries. The beneficiary is expected to be familiar with the law and regulation with regard to CHAMPUS coverage and exclusions and may not rely on a determination made by another insurance carrier or Medicare as to whether it is the type of care for which payment may be made under the CHAMPUS law and regulation.

Representations Made to the Beneficiary. The sponsor testified that at the time he was retired from the military he was told medical care would be provided to him and his family provided he met the requirements of the Regulation. It is his position in this hearing, of course, that he has met these requirements and there is an implication the government is going back on its word. What he was told was correct; as retired military he is eligible for CHAMPUS benefits, but the rest of his hearing statement is also true; he must meet the requirements of the law and Regulation. That is the issue in this hearing and it is my decision that part of the care rendered to his wife does meet the requirements but part of it does not; and as to such care not meeting the requirements, he is not entitled to benefits.

Erroneous Payment/Recoupment. An error did occur in processing this claim in that the fiscal intermediary initially paid for the care provided by Dr. Woodke during the period when hospitalization was denied. It is unfortunate that this occurred because it did raise the expectation that all of the other care had been erroneously denied and caused some delay in the processing. Notwithstanding the fact that an error may have occurred, it has no bearing on the final decision in this case. The CHAMPUS program is not bound by errors made by one of its employees or agents, and my appeal decision must be made on its own merits on the basis of the substantive issues in accordance with the authorizing statutes and applicable regulation governing the program. The substantive issue governing this case involves specific statutory provisions regarding custodial care which are binding upon me as Hearing Officer, OCHAMPUS and upon the sponsor and beneficiary irrespective of any error committed by the fiscal intermediary. Under the Regulation recoupment will be undertaken for any payment erroneously made for Dr. Woodke's services if the Assistant Secretary of Defense (Health Affairs) in his Final Decision finds that any part of the services were rendered in connection with custodial care.

BURDEN OF EVIDENCE

A decision on a CHAMPUS claim on appeal must be based on evidence in the hearing file of record. Under the CHAMPUS Regulation, the burden is on the appealing party to present whatever evidence he or she can to overcome the initial adverse decision. It is my determination that the beneficiary has presented evidence to overcome the initial adverse decision regarding the initial period of both hospitalizations, but beyond that has not.

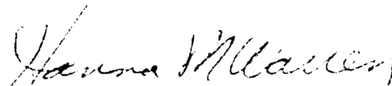
SUMMARY

In summary it is the Recommended Decision of the Hearing Officer that the care provided to the beneficiary at Eastern State Hospital from April 29 through May 5, 1982 be allowed but that inpatient care from May 6 through discharge on June 22, 1982 be denied as custodial care under DoD 6010.8-R, Chapter IV,E.12. Prescription drugs and one hour of skilled nursing care per day from May 6 through June 22 should be allowed.

It is further my Recommended Decision that inpatient hospital care provided at Sacred Heart Medical Center from August 1 through August 10, 1982 be allowed, along with the $321.25 for lab work, $111.00 for an EEG, $274.00 for a CT scan,

prescription drugs during the entire period of hospitalization, and one hour of skilled nursing care per day during the period August 11 through September 20, 1982. Care provided from August 11 through September 20, 1982 (except for prescription drugs and one hour of skilled nursing care per day) should be denied cost sharing because it was primarily custodial. I recommend that Dr. Woodke's services be cost-shared from August 2 through August 10, 1982, but denied after that date as care related to a non-covered condition and specifically excluded under DoD 6010.8-R, Chapter IV,E.12.c.

Dated this 31st day of July, 1984.



HANNA M. WARREN
Hearing Officer