ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

27 NOV 1984

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 84-33
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-33 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary who was represented by her stepfather, an active duty enlisted member of the United States Navy. The appeal involves the issue of CHAMPUS cost-sharing of claims for inpatient psychotherapy, provided to the beneficiary by both a psychologist and a psychiatrist during the period of June 17, 1982, through November 24, 1982. The amount in dispute is including $2,500 in CHAMPUS payments for psychotherapy by the psychiatrist and $4,480.00 in billed charges for concurrent psychotherapy by the psychologist.

The hearing file of record, the tape of oral testimony and argument presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that the inpatient psychotherapy provided by the psychologist concurrent to psychotherapy provided by the psychiatrist for the period of June 17, 1982, through November 24, 1982, be denied CHAMPUS cost-sharing. The Hearing Officer found that the beneficiary's medical condition was not so severe or complex as to necessitate concurrent care by the psychologist. The Hearing Officer also found a lack of adequate documentation to support a determination that psychotherapy by the psychiatrist was actually performed or that such services were appropriate and medically necessary for approximately 50% of the psychotherapy sessions claimed. Based on this finding, the Hearing Officer recommends that any undocumented claims for psychotherapy by a psychiatrist be considered improperly paid under CHAMPUS.

The Director, OCHAMPUS, concurs in the Recommended Decision and recommends adoption of the Recommended Decision as the FINAL DECISION. The Assistant Secretary of Defense (Health Affairs) after due consideration of the appeal record, concurs in the Recommended Decision of the Hearing Officer and hereby adopts the Recommended Decision of the Hearing Officer as the FINAL DECISION.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS cost-sharing of the appealing party's claims for the medical services of the psychologist provided concurrently with the treating psychiatrist. This determination is based on findings that the medical records do not indicate that the condition of the beneficiary was so severe or complex as to necessitate concurrent psychotherapy. In addition, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the claims for psychotherapy sessions with the psychiatrist for which the Hearing Officer could not find adequate evidence that the services were actually performed or that such services were appropriate and medically necessary are denied CHAMPUS cost-sharing.

FACTUAL BACKGROUND

The beneficiary, the stepchild of an active duty enlisted member of the United States Navy, was hospitalized on June 17, 1982, for the treatment of several behavioral problems including chronic elopement, abusive conduct toward siblings, loss of friends, general avoidance, withdrawal, and poor school performance. The beneficiary's initial diagnosis was Dysthymic Disorder and Passive Aggressive Personality. The final diagnosis was Major Depressive Disorder and Borderline Personality with avoidant passive-aggressive features.

The treatment during hospitalization consisted of individual therapy, group therapy, milieu psychotherapy, school, and activity therapy. Initially, individual psychotherapy was conducted by both the attending psychiatrist and a psychologist six times a week. Later the patient was seen by both therapists five times per week for individual therapy and one family session per week.

The Hearing Officer's Recommended Decision describes in detail the beneficiary's medical condition, the course of hospitalization, and the concurrent therapy provided by the psychiatrist and the psychologist. Because the Hearing Officer adequately discussed the factual record, it would be unduly repetitive to summarize the record, and the Hearing Officer's Recommended Decision is adopted in full and incorporated by reference in this FINAL DECISION. The Hearing Officer has provided a detailed summary of the factual background, including the appeals that were made, the previous denials, and the medical opinion of the OCHAMPUS Medical Director.

The hearing was held on March 14, 1984, at Waukegan, Illinois, before OCHAMPUS Hearing Officer, Joseph L. Walker. Present at the hearing were the sponsor and a representative from the OCHAMPUS Office of Appeals and Hearings. The Hearing Officer has issued his Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACTS

The primary issues in this appeal are: (1) whether the concurrent therapy provided by the psychologist was medically necessary and furnished at the appropriate level of care, (2) whether crisis intervention was necessary during the period in issue, and (3) whether the claims for psychotherapy by the psychiatrist are adequately documented to establish the actual performance of the therapy and the medical necessity and appropriateness of the therapy.

The Hearing Officer, in his Recommended Decision, correctly stated the issues and correctly referenced the applicable law, regulations, and prior precedential FINAL DECISIONS in this area; i.e., OASD(HA) Case File 16-79 and OASD(HA) Case File 83-10 which were issued by this office on March 31, 1980, and December 9, 1983, respectively.

The Hearing Officer found that there was no need for both a psychiatrist and a psychologist to treat the beneficiary. Because the condition of the beneficiary was neither complex nor severe, concurrent therapy was not medically necessary as defined by the Regulation and previous precedential FINAL DECISIONS. The Hearing Officer found that the beneficiary was in a crisis situation requiring crisis intervention psychotherapy because the beneficiary, on a particular occasion, exhibited extreme anger and threatening behavior which resulted in a transfer to the intensive care unit for close monitoring to prevent elopement; however, CHAMPUS cannot cost-share any crisis intervention psychotherapy because the record indicates that the psychiatrist only billed for the normal CHAMPUS limit of five 1-hour sessions during the period that the beneficiary was in intensive care. Therefore, while the beneficiary may have been in a crisis situation, no additional psychotherapy was administered and the Hearing Officer found that no additional CHAMPUS cost-sharing was in dispute. Finally, the Hearing Officer found that only 49 psychotherapy sessions by the psychiatrist were adequately documented in the records to establish the actual performance of the therapy and the medical necessity and appropriateness of the therapy.

Whether the Hearing Officer's finding regarding the issue of crisis intervention is correct is a moot issue in view of the absence of any claims for psychotherapy by the attending psychiatrist during the crisis period in excess of the normal CHAMPUS limit of 1 hour of psychotherapy in any 24-hour period. Aside from this issue, I concur in all other findings and recommendations of the Hearing Officer as fully supported by the appeal record. Additional factual and regulation analysis is not required. The Recommended Decision is accepted for adoption as the FINAL DECISION by this office.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the concurrent psychotherapy provided by the psychologist during the period of June 17, 1982, through November 24, 1982, because the use of concurrent therapy for this beneficiary was not medically/psychologically necessary and was not the appropriate level of care. In addition, it is determined that claims for psychotherapy by the psychiatrist during the period of June 17, 1982, through November 24, 1982, which were not found to be adequately documented in the record to establish the actual performance of the therapy and the medical necessity and appropriateness of therapy are denied CHAMPUS cost-sharing. The Director, OCHAMPUS, is directed to review this case for appropriate recoupment action for any erroneous payments made to the treating psychiatrist as suggested by the Hearing Officer in accordance with the Federal Claims Collection Act. The issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-0, chapter X, and no further administrative appeal is available.

for William Mayer, M.D.

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

In the Appeal of:

Beneficiary :
Sponsor :
Sponsor SSN :
Hearing Date: March 14, 1984

This is the Recommended Decision of CHAMPUS Hearing Officer Joseph L. Walker in the CHAMPUS appeal case file and is authorized pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R Chapter X. The appealing party is the sponsor, and active duty Navy E-8, and step-parent of the beneficiary. The appeal involves the denial of CHAMPUS cost-sharing for inpatient psychotherapy provided by a psychologist furnished concurrent to psychotherapy performed by a psychiatrist. The period under appeal is June 17 through November 24, 1982, and the amount in controversy is $4,480 in billed charges.

The Hearing file of record has been reviewed. It is the OCHAMPUS Position that the Formal Review determination, issued October 14, 1983, denying CHAMPUS cost-sharing of the services in question, should be upheld on the basis that the patient's condition was not shown to be so severe and complex as to require concurrent care as defined and excluded under Chapter IV, paragraph C.3.f. of Regulation DoD 6010.8-R and further that the care is denied in accordance with paragraph C.3.i.(1) and C.3.i.(2) of Chapter IV on the grounds that it was not shown that more than five hours per week or one hour per day of individual psychotherapy was necessary due to crisis intervention. OCHAMPUS also takes the position that any sessions over five per week billed by the psychiatrist must also be denied.

The Hearing officer, after due consideration of the appeal record, concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing for all services rendered by the psychologist.

FACTUAL BACKGROUND

On June 17, 1982, the beneficiary (date of birth 8/13/67) was hospitalized for the treatment of a number of behavioral problems including chronic elopement, abusive conduct toward siblings, loss of friends, general avoidance and withdrawal, and poor school performance. The initial diagnosis was Dysthymic Disorder and a Passive Agressive Personality. Final diagnosis was Major Depressive Disorder and Borderline Personality with avoidant passive-agressive features. Following medical and psychological testing, treatment began consisting of six psychotherapy sessions per week each by a psychiatrist (an M.D.) and by a psychologist (a Ph.D.), and later in the admission, five such sessions per week and one family session per week. (Exhibit 30)

CHAMPUS claims for the hospital charges and the professional fees of the psychiatrist and psychologist were subsequently submitted to Wisconsin Physicians Service, the CHAMPUS fiscal intermediary (Exhibit 1). The claims were partially cost-shared by the intermediary, but on November 22, 1982, the case was referred to the American Psychiatric Association for peer review (Exhibit 22). The three reviewing psychiatrists replied to the intermediary that an opinion was not possible due to the large amount of documentation and lack of a concise treatment summary. On December 10, 1982, the intermediary notified both the sponsor and the hospital of the results of the peer review (Exhibit 26), denying further CHAMPUS benefits without additional documentation. Following the receipt of that documentation, the case was again referred to the American Psychiatric Association for a second review. On February 9, 1983, the intermediary advised the sponsor and the hospital that the peer reviewers had found the case to be medically necessary and appropriate and that the length of stay was appropriate (Exhibit 35). Subsequently, benefits were extended in accordance with that decision.

With regard to the psychologist's services, the record shows that sixty-four (64) sessions were billed during the admission at a rate of $70.00 per session (Exhibits 1 and 34). In processing the claim, the intermediary cost-shared a total of $3,068.00 and rejected one claim for $770.00 as "non-covered concurrent care". Following the sponsor's request for a review of that decision, the fiscal intermediary affirmed its determination on January 25, 1983 (Exhibit 31). Automatic reconsideration followed, and on March 8, 1983, the sponsor was notified that none of the care provided by the psychologist could be allowed on the grounds that reimbursement could be made for the services of only one provider. A subsequent letter to the sponsor advised that the previously paid $3,068.00 for the psychologist's services was in error and a refund was requested (Exhibits 37 and 38).

On April 26, 1983, the sponsor requested a review of the matter by OCHAMPUS. The results of that review, based in part on analysis of the case by the OCHAMPUS Medical Director, was that no evidence had been presented to indicate that crisis intervention had been necessary, and thus benefits would be limited to five one-hour sessions per week. No benefits were allowed for the care by the psychologist on the basis that it had not been demonstrated that it was medically necessary or appropriate for two therapists to be involved in the psychiatric care of the patient (Exhibit 44).

The sponsor requested a hearing on November 25, 1983, and the hearing was held before the undersigned CHAMPUS Hearing Officer on March 14, 1983, in Waukegan, Illinois. Those present at the hearing included the sponsor, and Barbara Udelhofen, Attorney/Advisor for OCHAMPUS.

ISSUES AND FINDINGS OF FACT

The issues in dispute are (1) whether the concurrent care by the psychologist was medically necessary and furnished at the appropriate level, and (2) whether crisis intervention existed during the period at issue and whether such benefits can be extended

Additional issues that will be addressed include the responsibility of the hospital and/or physicians in furnishing patient care, misinformation by the base CHAMPUS office, and CHAMPUS coverage of the psychiatrist's charges.

Medical Necessity/Appropriate Medical Care

The statutory authority for the payment of certain medical charges can be found in Chapter 55, Title 10, United States Code. Regulation DoD 6010.8-R, promulgated under the authority of and in accordance with the statute, established policy for the worldwide operation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

A general definition of CHAMPUS, from Chapter IV of the Regulation, is cited in pertinent part herein:

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 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, other authorized institutional providers, physician and other authorized individual professional providers as well as professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment.

The Regulation defines the terms "medically necessary" and "appropriate medical care" in Chapter II (Definitions), as follows:

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

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

a. That medical care where the services performed in the treatment of a disease or injury, or in connection with an obstetrical case, are in keeping with the generally accepatble norm for medical practice in the United States;

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

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

Concurrent Care

The Regulation discusses concurrent care and the CHAMPUS psychiatric benefit in Chapter IV, as follows:

C. Professional Services Benefit

3. Extent of Professional Benefits

f. Inpatient Medical Care: Concurrent. If during the same admission a beneficiary receives inpatient medical care (non-emergency, non-maternity) from more than one physician, additional benefits may be provided for such concurrent care if required because of the severity and complexity of the beneficiary's condition. Any claim for concurrent medical care must be reviewed before extending benefits in order to ascertain the medical condition of the beneficiary at the time the concurrent medical care was rendered. In the absence of such determination, benefits are payable only for inpatient medical care rendered by the attending physician.

i. Psychiatric Procedures.

(1) Maximum Therapy Per Twenty-Four (24)-hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than one (1) hour of individual and/or group psychotherapy in any twenty-four (24)-hour period, inpatient or outpatient. However, for the purpose of crisis intervention only, CHAMPUS benefits may be extended for up to two (2) hours of individual psychotherapy during a twenty-four (24)-hour period.

(2) Psychotherapy: Inpatient. In addition, if individual or group psychotherapy, or a combination of both, is being rendered to an inpatient on an ongoing basis (i.e., non-crisis intervention), benefits are limited to no more than five (5) one-hour therapy sessions (in any combination of group and individual therapy sessions) in any seven (7) day period.

In considering the concurrent care issue of this appeal, it is necessary to establish the attending physician. The Regulation (Chapter II) provides as follows:

> B.16. Attending Physician. "Attending Physician" means the physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, an assistant-at-surgery or an anesthesiologist is not an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time.

As indicated, it is the OCHAMPUS position in the matter that it has not been shown that the patient's condition was so severe or complex as to require the concurrent services of a psychiatrist and a psychologist, nor that crisis intervention was involved in this case. At the hearing, the sponsor testified that the beneficiary often "got wild" and on several occasions the "time-out" room or "straight jacket" was utilized to control her. The sponsor further testified that his daughter often required sedation or had to be "tied down" and that on one occasion spent two weeks in the intensive care unit of the facility. When asked the approximate dates of these occurences, the sponsor could not say. In reviewing the daily progress notes from the hospital confinement, the Hearing Officer notes that from admission until July 6, and again during the period July 12 to August 3, the beneficiary was "unit restricted". She was moved to the facility's intensive care unit on August 31 where she remained until September 10. Upon return to her room, the beneficiary was again unit restricted until September 29. The primary concern of the staff during the restricted periods was with elopement. The intensive care confinement was necessitated because of the beneficiary's extreme anger and threatening behavior toward a peer, according to the hospital progress notes.

It is the psychiatrist's contention that two therapists were necessary because "the patient was very primative in her thinking and required concrete examples of mother and father interactive and therapeutic role modeling". According to the therapists, "conjoint therapy enabled re-parenting and a formation of a more stable identity" and

that "the use of a male and a female therapist working individually and together, facilitated this process of re-parenting". (Exhibit 34). Neither the American Psychiatric Association peer reviewers not the OCHAMPUS Medical Director (a child psychiatrist) however could support the need for two attending providers.

The Office of the Assistant Secretary of Defense (Health Affairs), the final authority in the CHAMPUS Program, has issued two previous final decisions in hearings where concurrent care by a psychiatrist and a psychologist was at issue. Key excerpts from those decisons are as follows:

> OASD(HA) Case file 16-79
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> "Severity of Patient's Mental Illness. First it was claimed by the appealing party that the patient's mental illness was so serious and severe that it justified two primary practitioners rendering concurrent individual psychotherapy to the patient. The clinical information submitted in this case was minimal. The patient did appear to have significant symptomatology prior to her initial hospital confinement. She had agreed to outpatient psychotherapy with the appealing party which apparently intensified some of her symptoms, particularly suicidal and homicidal ideation, and it was determined hospital confinement was required. There was no evidence presented of aggressive or self destructive acts prior to confinement, however. Symptoms presented on admission to the hospital were related as anxiety, depression, aggitation (sic), anorexia and insomnia. While the Hearing File of Record suggests the existence of a significant mental disorder for which hospital confinement was no doubt appropriate, because complete clinical records were not provided, it was not possible to support a finding that the patient's condition was of such severity and complexity that she required, in addition to the hospital confinements and the attending psychiatrists, concurrent in-hospital individual psychotherapy by more than one primary practitioner. The regulation speaks to the issue of concurrent in-hospital medical care provided by more than one physician. While in this case the appealing party is a clinical psychologist rather than a physician, the intent of the regulation is clear and it would not be reasonable to apply less restrictive

> standards to the services of a clinical psychologist than to a physician. In the absence of clinical evidence indicating that the patient's condition was so severe and complex as to require concurrent individual psychotherapy, a negative finding must be assumed. (Reference: CHAMPUS Regulation DoD 6010.8-R, chapter IV, section C, paragraph 3.f.)"
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> OASD(HA) Case file 83-10
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> "It was the Hearing Officer's opinion that the circumstances in this case do not satisfy the above indicated requirements. I agree. As in OASD(HA) Case File 16-79, the current appealing party's problems were of the type for which hsopital confinement was appropriate, but it has not been established that the required care was beyond the controlled environment of a hospital, its staff, and a single attending physician (provider).
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> The Hearing Officer also concluded that the record does not support 'the presence of complex, serious, and multiple, but unrelated, medical conditions'. As noted by the Hearing Officer, inherent differences between psychiatrists and psychologists exist in education and treatment approaches; however, the primary focus of the CHAMPUS regulation is not the practitioner's treatment, but the patient's condition.
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> The reviewer from the CHAMPUS American Psychiatric Association Peer Review Project, stated that:
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> > 'The record does not make clear the clinical indications for having a psychiatrist and a psychologist see the patient on the same day; a most unusual practice'."

As noted, in both Case File 16-79 and 83-10, it was found that hospital treatment, and the protective environment afforded therein, was appropriate treatment. In neither case, however, did the medical records support the need for a psychiatrist and a psychologist treating the same condition due to the complexity or seriousness of the condition. Preponderance of the evidence in the present case demands the same conclusion. With the exception of certain isolated occasions where non-psychiatric medical care was needed by the beneficiary and covered by CHAMPUS, (i.e., examinations for a sore throat, injured finger, etc.) the record does not support the need for concurrent care as defined by the Regulation and in compliance with previous Final Decisions. Although both therapists

served equally in the treatment of the beneficiary, the psychiatrist is considered to be the attending physician because a medical doctor normally assumes that role, with the services of other providers incidental to the patient's care. Further, the psychiatrist may have been responsible for monitoring and prescribing medication, depending on appropriate state law.

Crisis Intervention

Having determined that (1) the psychiatrist was the attending physician in the case, and (2) the psychologist's services are not covered on the grounds that the need for concurrent care has not been established, it remains to be decided whether or not additional benefits can be extended for the psychiatrist's services due to crisis intervention. As noted earlier, the Regulation limits CHAMPUS coverage of psychotherapy to no more than one hour per 24-hour period unless for purposes of crisis intervention. In that event, benefits may be extended for up to two (2) hours per 24-hour period.

It is the position of OCHAMPUS in this appeal that the record fails to show "that the patient was at any time during the course of hospitalization in a crisis situation". The Hearing Officer must disagree. Staff progress notes indicate that the beneficiary and another patient had planned an elopement from the hospital and on August 30, the other patient notified the staff. The beneficiary exhibited extreme anger and threatening behavior and was transferred to the intensive care unit where she remained until September 10. She was closely monitored for elopement during the period. These events would, in the Hearing Officer's judgement, suggest a crisis situation. The existence of a crisis period, however, is a moot point since the record indicates that the psychiatrist billed for only five one-hour sessions per week during that particular period of time. (Exhibit 1, page 37). While the beneficiary may have been in a crisis situation, there was no additional psychotherapy administered and thus no additional CHAMPUS benefits are due.

Record Documentation

Exhibit 20 of the Hearing File of Record contains physician daily progress notes from the beneficiary's hospital record, showing who saw the patient during each day and the results of that particular visit. In the present case, entries have been made by the psychiatrist, psychologist, staff therapists and other physicians, as appropriate. The records furnished, however, are voluminous, somewhat difficult to read and are incomplete. (Although the date of discharge was November 24, the progress notes stop at October 18.) Additionally, copies of CHAMPUS claims, Explanation of Benefit Forms and physician billings are likewise incomplete and difficult to read. Nonetheless, in reviewing the documents in question, the Hearing Officer finds a serious lack of daily progress notes on the part of the psychiatrist - attending physician. Although CHAMPUS benefits have been claimed for five to six one-hour psychotherapy sessions per week, and benefits have been extended on that basis, the record contains written entries for only about one-half of the sessions claimed. CHAMPUS will cost-share only those medically necessary services which are appropriately and adequately documented. In the absence of such documentation, it is difficult to determine that services were actually performed or that the services were appropriate and medically necessary.

For the period June 17 through October 18, the Hearing Officer finds appropriate documentation of services rendered by the psychiatrist, as follows:

	June	: 17, 18, 21, 22, 25, 28, 30
	July	: 2, 5, 6, 9, 12, 13, 16, 19, 21, 22, 23, 26, 27, 30
*	August	: 1, 2, 3, 5, 23, 24, 27, 30, 31
	September	: 2, 6, 7, 9, 14, 15, 16, 20, 21, 23, 28, 29
	October	: 1, 5, 6, 8, 11, 13, 14

* Dr. L. Pollack assumed care of the beneficiary from August 8-29.

The Hearing Officer recommends that any sessions billed by the psychiatrist during the June 17 - October 18 period that were paid by the intermediary and not shown as documented be considered improperly paid and the appropriate action taken. It is further recommended that the hospital progress notes be obtained for the period October 19 - November 24 and similarly reviewed.

Secondary Issues

Hospital/Physician Responsibility

At the hearing, the sponsor testified that it was the hospital and the physicians who decided what care would be given and who would carry it out. The sponsor said that he didn't know what was needed in the treatment of his daughter - that "they" should know. He testified that he shouldn't have been put in this position and that he was "the victim".

While the Hearing Officer can appreciate the sponsor's exasperation in dealing with the medical professionals involved in his daughter's care, his feelings do not change the facts of the case. While CHAMPUS is a complex medical benefits program covering a wide range of services, it has an obligation to cover only those services which have been authorized by Congress. Further neither the Hearing Officer nor CHAMPUS implies that the care furnished the beneficiary was inappropriate or improper - only that it exceeded the statutory limits of the Program.

Misinformation by Base CHAMPUS Office

The sponsor testified that he was misled by the Base CHAMPUS office at Great Lakes, Illinois, and that personnel there told him CHAMPUS would cover all costs. He said that the only advice that the CHAMPUS office could give is to "appeal". He feels that he should have been informed of the situation at the time the Nonavailability Statement was issued.

With few exceptions, CHAMPUS is an "at risk" program, meaning the benefits or cost-sharing become available only after the filing of a CHAMPUS claim with the intermediary, who issues CHAMPUS benefit payments within the framework of the Regulation. The primary function of the base CHAMPUS office is to generally advise beneficiaries as to how to obtain those benefits. Such offices do not issue binding opinions and it is regrettable that the sponsor formed that opinion. Only OCHAMPUS and its intermediaries are empowered to make claim determinations - base CHAMPUS offices and CHAMPUS advisors serve only an administrative role in assisting those seeking benefits. Further, due to the highly technical nature of CHAMPUS and the claims filed thereunder, it is not reasonable to expect base offices to provide such detailed advice.

SUMMARY

It is the Recommended Decision of the Hearing Officer that the denial and/or overpayment determination of OCHAMPUS be affirmed on the grounds that the beneficiary's medical condition did not warrant concurrent care by the psychologist, Dr. C. C. Anderson, as defined by Regulation DoD 6010.8-R, IV.c.3.f. Further, the Hearing Officer finds that no additional benefits may be extended for the services of Dr. Howard Klapman for crisis intervention (IV.c.3.i.) on the grounds that no such additional services were rendered or claimed. The Hearing Officer additionally recommends that payments for undocumented services by Dr. Klapman be considered erroneous payments and handled accordingly by OCHAMPUS.

Joseph L. Walker
CHAMPUS Hearing Officer

Columbus, Ohio

May 15, 1984