ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

27 NOV 1984

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) Case File 84-35
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-35 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS provider, National Jewish Hospital/National Asthma Center. The appeal involves the denial of CHAMPUS cost-sharing of inpatient psychiatric care including related professional care from May 23 through August 11, 1982. The amount in dispute is approximately $23,100.00.

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 the inpatient care provided February 22 through May 22, 1982, but deny cost-sharing of the care May 23 through August 11, 1982. The Hearing Officer found the care from February 22 through May 22, 1982, to be medically necessary and provided at the appropriate level of care, but found the care from May 23 through August 11, 1982, was not medically necessary and provided above the appropriate level of care.

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.

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 the FINAL DECISION.

In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence in this appeal. The findings are fully supported by the Recommended Decision and the appeal record. Additional factual and regulation analyses are not required. The Recommended Decision is acceptable for adoption as the FINAL DECISION by this office.

For clarification, I note the hospital claims include a daily professional charge of $50.00 per day. As no individual professional claims appear in the record, it appears that the hospital included the charges for the individual psychotherapy and medical management as part of the hospital claims. As the file indicates the attending psychiatrist was an employee of the hospital and not an individual professional provider, no separate CHAMPUS claims for the psychotherapy should have been filed. The Hearing Officer properly recommended denial of cost-sharing of the related professional charges under DoD 6010.8-R, chapter IV, G.66. To the extent claims for professional services were filed in addition to the hospital claims, such claims are denied under that regulation exclusion.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to authorize CHAMPUS cost-sharing of the inpatient psychiatric care from February 22 through May 22, 1982, and to deny cost-sharing of the care provided May 23 through August 11, 1982, as not medically necessary and provided above the appropriate level of care. As the file notes other insurance was available for cost-sharing of the care, the Director, OCHAMPUS, should direct the fiscal intermediary to consider other insurance payments in the cost-sharing of the care from February 22 through May 22, 1982. The appeal and claims of the provider are, therefore, denied. 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: SSG, USA (Retired)
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 provider, National Jewish Hospital/National Asthma Center, and the appeal involves the denial of CHAMPUS cost-sharing for inpatient psychiatric hospitalization from May 23, 1982 through August 11, 1982. The amount in dispute is approximately $30,800.00 in billed charges which would result in CHAMPUS benefits of $23,100.00 after deduction of the patient-pay amount.

The hearing file of record has been reviewed along with the testimony given at the hearing and the arguments made by the appealing party. It is the OCHAMPUS position that the Revised Formal Review Decision, issued January 24, 1984, denying CHAMPUS cost-sharing for the inpatient hospitalization beyond 90 days be upheld on the basis that the care was not medically necessary and was above the appropriate level of care required for treatment of the patient's condition.

The Hearing Officer, after due consideration of the appeal record, concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing beyond 90 days of hospitalization. The recommended decision of the Hearing Officer is therefore to deny cost-sharing for the beneficiary's inpatient hospitalization and related care from May 23 through August 11, 1982.

FACTUAL BACKGROUND

The beneficiary was twelve years old when he was admitted on February 22, 1982 to National Jewish Hospital/National Asthma Center, hereinafter referred to as "Hospital." The diagnosis on the claim form was given as asthma, and psychic factors associated with asthma. The charge on his admission and for the first period of care was $225.00 per day, plus an ancillary charge of $250.00 per day and a physician charge of $45.00, or $520 per day. The claim stated charges were not itemized (Exhibit 1, page 2). The patient remained on the medical unit until the 38th day of hospitalization, when he was transferred to the pediatric/psycosomatic ward, which is known as the 2-May unit. He remained on this unit until August 11, 1982, when he was discharged. The charge for the period of time on the 2-May unit was $200.00 per day plus a daily ancillary charge of $150.00 and a daily physician charge of $50.00, or $400.00 per day.

There is an extensive social service opening sheet called Pre-admission which is dated February 11, 1982 (Exhibit 4), although it must have been dictated after admission. It describes the patient and his parents, stating they had planned to stay the first full week but delays had used up the father's allotted time off and they stayed only three days. The mother is described medically as "a walking time-bomb," subject to "drop dead" at any time because of Systemic Lupus Erythematosis, diagnosed 1966; Sarcoidosis, and Coronary artery disease/congestive heart failure, secondary to the SLE. The father had a pneumonectomy for cancer in September 1980 and there was some suspicion on the part of the social worker that he had a drinking problem and might be fearful to both his wife and son. The social worker filing the report said for the past year the patient's symptomology had been steadily increasing and that Fort Campbell, Kentucky, where the patient lives, now has an allergist, formerly an NJH Fellow, who recognized the severity of his symptoms. This report contains the following: "Family therapy was recommended post-discharge NAC (with previous hospitalization). Unfortunately they were not supported sufficiently by the therapist or the system; so in effect, they had no follow up therapy. Their first social worker transferred out without even telling them and the second social worker has been only minimally involved." In describing the physical data, the report states that during the patient's previous hospitalization, which appears to have been for six months, he showed some problems in visual motor skills and needed tutoring. When he was discharged from the hospital he was on a hyposensitization program with shots three times weekly, terminating December, 1981. The report continues: "Medically the first year post NAC he had only minimal problems. In summer of 1981 he had two or three hospitalizations; beginning the new school year, August 1981 in a new junior high school, he had 13 hospitalizations to the present, missing about 20 days of school." She states that the parents were anticipating the hospitalization to be short, only to readjust his medication, and describes the interpersonal relationships as "characterized by a distant and flattened affect," noting that the patient gets a lot of emotional support and help from his nearby maternal aunt who has already been selected to take care of him in the event of his mother's death.

The admission summary (Exhibit 5) was signed by Drs. Squire and Brenner. In the history section of this admission report, it reports that for the previous chronological year there had been one hospitalization for a month and approximately 24 emergency room visits. According to the referring physician, an estimated 10 days of school were attended during the calendar year 1981 and according to the parents, all but four or five days attendance in January of 1982. I think this must be an error. It certainly does not correspond with the report of the social worker or other material in the file. The most severe episode reported with the patient occurred in 1977 when he was unconscious with respiratory failure, intubation, and mechanical ventilation complicated by pneumothorax and endopericardium. The systems review was unremarkable as was most of the physical examination. In the assessment portion of the admission summary, three diagnoses were given: "(1) perennial asthma, moderately severe with essentially a high degree of liability. Question of fixed small airway obstruction; (2) eczema; (3) perennial rhinitis, by history." The first plan

was to administer a "short course of daily prednisone, 30 mg. qid. while observing. Pulmonary functions to determine the degree of reversability of small airway obstruction." The second plan was, "Development of a specific plan while monitoring peak flow measurements and precise recommendations with respect to adjustments of medical regimen and physician contact." The third goal was "additional evaluation to include review of prior food skin testing and repeat skin testing as indicated; opthamology consultation, bone age, and cortisols, and Eucerin for atopic rhinitis" (Exhibit 5, page 3).

The record shows an orthopedic consultation on March 22 for left shoulder pain, which was diagnosed as a probable sprain and a sling with arm rest was recommended (Exhibit 6, page 2). On March 26 a physical therapy consultation was requested regarding the left shoulder sprain. The patient was given exercises to do on his own (Exhibit 6, page 1). A psychology consultation was requested on March 3, 1982 and the psychological evaluation summary is as follows: "This twelve year old boy of low average intelligence (previous testing) appears to have some impairment in his ego functioning. He seems to be working to suppress his emotions, including anxiety, but this results in constricted and stereotype thought processes. As a result of his poor integration and inadequate defenses, he periodically shows unrealistic and unusual thoughts and perceptions." In her recommendations, the psychologist recommends individual psychotherapy with a goal of establishing a relationship with the patient to help him allow his feelings and ideas to emerge. " needs assistance in handling his anxiety about physical illness in his family and in exploring relationships between stress and his asthma." The second recommendation was that the staff within the milieu therapy setting could work on sincere relationships and that they should be aware that his compliance when others are watching may not reflect internalized behavior problems (Exhibit 6, page 5).

There was a consultation with audiology which showed the patient had normal hearing (Exhibit 6) and a recreation therapy evaluation was made. It reports the pastient is in the sixth grade in a regular school program with remedial classes in math and reading. He enjoys school, could be an A student if in school more often and during second and third grades, because of his frequent absences, he had a home bound teacher. She states: "Asthma has not seemed to interfere to a great degree in s social life. He enjoys playing football, basketball, bowling, skating, computer games and models." She found that his gross motor skills appeared to be his strong point and the goal was to improve his math skills through participation in recreation activities requiring those skills and to develop his swimming skills and participation in co-ed activities to help him be more comfortable with females (Exhibit 8). The educational screening showed the patient to be in grade 3.6 in math, 3.1 in reading, and 2.7 in spelling (Exhibit 9). The record also contains an occupational therapy evaluation (Exhibit 10) and reports some scores as to visual motor skills two years below his chronological age, with the recommendation that the patient attend occupational therapy one to two times weekly "individually to improve visual perceptual skills, including visual motor space and form perception and eye convergance/tracking skills."

At the time of the patient's transfer to the 2 May unit on March 30, 1982 there is a transfer discharge statement from psychology (Exhibit 12). It shows the dates of evaluation as March 16, 18 and 23 and, since it in abbreviated form contains essentially the same recommendation and problem description as the original report described above (both were signed on March 30, 1982), it appears that one series of testing was done and both of the psychology reports are the result of that testing. Again, individual psychotherapy is recommended to help the patient integrate his views of himself and the world and handle his anxiety related to extremely serious physical illness in his family, along with the same recommendation for the staff to establish a sincere modeling relationship with the patient.

There is also a transfer statement from recreational therapy that recommends continued participation in co-ed activities and swim instruction (Exhibit 12, page 2); from OT stating that occupational therapy had just begun the past week and would continue (Exhibit 12, page 4); from physical therapy which recommends continuing of self-monitoring with exercise program and improving his swimming strokes (Exhibit 12, page 5); from school, which again reiterates the patient is approximately three years behind grade level in reading and math, and that he requires extra help in all academic subjects (Exhibit 12, page 6). The transfer statement from nursing describes his medication and states: "Has had few problems with his asthma" (Exhibit 12, p.3). The report continues, "He has required a tremendous amount of self-care meetings. Much of the information ..... has needed to learn has had to be explained to him because he has problems with written language concepts...Basically has a workable knowledge of his meds. has not had an exacerbation of his asthma since he was admitted to the hospital. Therefore a longer stay on 2-May may be beneficial to evaluate panic handling capabilities and ability to do wheezing protocol." Under "special considerations" it states both his parents would benefit from taking the asthma medication class and discusses the concern the parents' health has on . needs extensive workup requiring the 2-May program so that he may be more proficient in self care and hopefully the home situation will have improved by the time he returns." The report discusses an altercation the patient had with another patient and his sore shoulder, and under "social situations" reports he had problems getting along with the other children wants to use his fists instead of his reasoning powers but concludes, has improved in coming to a staff member with social problems."

The transfer summary (Exhibit 13) signed by Drs. Squire and Brenner, who treated before he was transferred to 2-May, is a little difficult to interpret because it appears it was not written at the time of the transfer on March 30th, but in July, which was getting very close to, and in anticipation of, the patient's return home. The diagnosis again is moderately severe bronchodilator dependent asthma, possibly with a seasonal allergic component, seasonal allergic rhinitis, atopic dermatitis, history of tuberculosis exposure, history of shoulder pain and social situation. It discusses the routine therapy for the dermatitis, asthma and rhinitis and recommends "regular medical supervision by one physician, perferably an allergist or a physician specifically interested in the management of atopic disorders. Intensified social services support with one social worker coordinating efforts, family

counseling for parents prior to and after 's return home." In the discussion of problems, the doctors say his asthma is fairly well controlled, no evidence of breakthrough or deterioration but that is always a possibility and he needs to be consistent in administering medication with early detection and intervention if problems occur. Under the social situation problem the report again describes the multiple medical problems suffered in the family; "aggressive contact with social services at the referring institution, and in-depth psychological assessment and intervention program have been undertaken with Dr. Bruce Miller's direction. It is necessary that the aggressive support of a primary physician working in conjunction with the social services department will be necessary to help this family optimally manage 's asthma, which is eminently controllable. Prior to transfer a conversation with Dr. Tony Bunker of the Allergy Service at Fort Campbell Hospital, Fort Campbell, Kentucky, was placed to appraise the situation and transfer and the anticipated duration of further psychological intervention efforts, and the possibility of him acting as primary physician upon . 's return to the Fort Campbell area" (Exhibit 13, page 4). The information received during this call is not given in the report.

The initial recreation therapy report after the patient was transferred to 2-May shows he was going to participate in unit group activities, games and psychodrama with the goal of developing trust in authority figures, improving socialization skills, channeling aggression into therapeutic activities, decreasing impulsivity and developing new interests and talent (Exhibit 14).

The social service transfer sheet (Exhibit 15) discusses the patient's admission for treatment of his asthma and chronic psychosocial difficulties and discusses his parents' medical illness and his reluctance to discuss his medical problem because it might exacerbate theirs. It reports his parents are fairly distant with each other and, "an additional problem existed in the fact that adequate psychological care was not provided in the home community (the father is retired military). Due to the above considerations, transfer to 2-May was recommended and initiated to help and his family address some of the above-mentioned problem areas. It was also felt that it would take some time to arrange for psychological care to be provided outside of the military base. So, given the family's resistance to psychotherapy in the past, it was felt that this process could begin while was on 2-May since the parents do have the capability of coming out here through military transport."

Dr. Bruce Miller, who is a general and child psychiatrist, was the physician responsible for the beneficiary's care on the 2-May Unit. He wrote bi-monthly notes in the hospital chart and the first is on March 31, 1984, and is called "Psych Transfer Note" (Exhibit 41). Dr. Miller reviewed the chart and saw the patient for about one-half hour:

> was cooperative and spoke openly about issues important to him--namely his illness and that of his parents. He became tearful when talking aboutissues relating to separation and loss, stating that "it is easier for adults to deal with than children." His

mood did appear to be anxious and mildly depressed, and his affect was constricted. Thinking showed no thought disorder but clear preoccupation with sickness and loss.

Information provided by other evaluations herein as well as obtained in my interview, suggest that is frightened and anxious about his and his parents' illness, and has not developed a useful means of dealing with his concerns. I believe he is mildly depressed and overwhelmed by his inner feelings of helplessness."

Goals were to help the patient develop more adaptive ways of dealing with his concerns and improve his interpersonal skills with individual psychotherapy and miliew therapy to improve interpersonrelationships. The length of stay was estimated to be 2-4 months.

The April 16, 1982 Psych Progress Note states: "Related to problems 5, 6 and 7, I believe that the situation at home and 's inability to recognize and deal with his internal feelings cause him to feel depressed. I believe this is the cause of his low frustration tolerance and frequent "outbursts" and his frequent crying when under minimal stress. is being seen in individual therapy and is responding positively to this intervention. As well, his function on the ward and in activities is showing positive response (see RN note 4/16 and counselor note 4/15)" (Exhibit 41).

The May 17th psych notes states that Dr. Miller spoke with the home social worker, Captain Lewis, who reported that the patient's family situation had deteriorated with the mother in the hospital and "father unavailable to help provide stable home situation." Alternative considerations were discussed regarding the unstable home situation and the incentive for the parents to get help. The report states, "Captain Lewis to further assess family situation and consider alternative solutions with parents. Dr. Miller to be in touch with Captain Lewis re further considerations to 's discharge." The patient was been showing some deterioration of function over the past two weeks which Dr. Miller believed reflected his awareness of the problems at home. Recommendations were that the staff continue to be supportive and that he would continue individual psychotherapy "to deal with his feelings and responses to family situation." It concludes, "Begin exploration of discharge plan/alternative with David."

A counselor's note on May 16 shows the patient received a call from home and was tearful after the phone call saying he wanted to go home (Exhibit 18, page 40). The May 20 Fellow's note shows that calls were placed to Dr. Walker, the referring physician, to "inform him about stable course of asthma". There is a promise to call him after clinical meeting to give a projection for the length of stay. It also shows he spoke to Mrs. who said she was planning a trip from their home to Denver to California and return, for approximately 14 days, and wanted to know if she could pick up during that time (Exhibit 18, page 38).

On May 27, 1982 there is psych progress note written by Dr. Miller which states, "Followup discussion with Captain Lewis indicates that family situation has deteriorated further in that there are no resources in place for caring for . I spoke with Mrs. two days ago and she indicated she was planning a trip to California to 'recoup' and that she was unsure of when this would be, and when she would feel up to caring for on a regular basis. No resources in place for to go home to presently or in near future." The note continues, "Continued contact with Captain Lewis and social worker to try and explore a suitable environment for was recommended along with following the family's progress and concludes: "As per clinical meeting review past Wednesday, plans for extended therapy for on 2-May for following purposes: (1) allow time for home situation to be clarified one way or the other, social worker to actively participate; (2) work with in individual therapy on accepting and working through the family problems he is and has been experiencing; (3) continue milieu program for increased self care skills." This note reports the patient "responded with distress at learning he would be staying additional time on 2-May." Recommendation was to be followed in individual therapy and supportive milieu (Exhibit 18, page 36).

The clinical social worker notes of June 8 show the patient's mother appeared unexpectedly on Saturday, June 5, and the patient went on pass with his mother but she left early the morning of June 8 before any conference could be scheduled (Exhibit 18, page 32). The weekly counselor's summary of the same date shows that the patient spent three days with his mother and separated from her very well.

On June 18 there is a typewritten bimonthly progress note signed by Dr. Miller (Exhibit 20), which states he had spoken with the mother a week before and the father was drinking heavily. There was some question as to whether the family would break up, her sister's family situation is presently disrupted and "there will be some clarification of her availability as a resource and support person for by the end of June." It is planned they will continue to keep in contact with the mother and the social worker to determine "whether will return home in August or whether he will have to be placed in an alternative care setting." It goes on to describe the patient's behavior on the unit as much improved. "He is on Honors level and has been handling frustration and confrontation much better. In individual psychotherapy weekly he is more readily talking about his uncertain family situation. His mood is much more cheerful and his affect is full range and bright". He describes the patient's ability to more realistically accept his family situation and this is "seen as a positive coping strategy, and consequently his depression has dramatically improved."

There is a psych progress note dated July 2 which reports Dr. Miller met with the parents and the patient when they were in Denver. The parents showed some awareness of their need for help regarding their problems and its affect on their son's asthma. The recommendation was there would be family therapy with Captain Lewis or other capable therapist to be started prior to discharge (Exhibit 18, page 13).

On July 9, 1982, the Psych Progress Note reported a discussion of the family visit and " responded appropriately to family visit and identified problems. His behavior has been good and in keeping with honors level. He has shown responsibility for self care and needs. He does not appear to be depressed any longer" (Exhibit 18, p.11). The next psych progress note on July 16 discussed discharge planning and contact with Mr. and Mrs. and Captain Lewis, the social worker. He stated the family planned to stay together and he was referring them for marriage counseling and setting up a program for the entire family for counseling when the patient returned home. He was going to follow up contact with the within a week to firm up discharge date and states, "Discharge treatment and planning proceeding. Continue plans for discharge for the first or second week in August depending on mother's availability to get out here and pick up" (Exhibit 18, page 12). The same note shows there is a new pediatrician on the base and it recommends that Dr. Tanaka contact the new pediatrician and "catch her up on the medical and psycosocial aspects of 's care as we have seen them here" (Exhibit 18, page 9).

The psych progress note for August 2, 1982 discusses discharge planning and reports that Dr. Miller spoke with the mother and discussed marriage counseling and also some family counseling to include the patient and "Plans are intact." A discharge date was set for August 11 (Exhibit 18, page 3). The note for August 6 by Dr. Miller shows that he spoke with Captain Lewis and "All systems go" for discharge plans and follow-up therapy. The patient's mother and father are to drive out to arrive in Denver on August 9 (Exhibit 18, page 1).

The discharge summary signed by Drs. Tenaka and Brenner essentially describes what was discussed before regarding the patient's asthma. They give the results of the pulmonary function tests and what allergins he should avoid. In the discussion of the social situation they and state it is necessary that there be "aggressive support of a primary physician working in conjunction with the social service department" to help the family manage the patient's asthma and goes on to report it is their understanding that Dr. Tony Bunker-Soler of the allergy service at Fort Campbell Hospital will act as the primary physician upon 's return home (Exhibit 22, page 5).

Ninety days of inpatient hospitalization were exceeded on May 23, 1982 and on July 13, 1982 the sponsor submitted a request for extension of CHAMPUS hospital benefits beyond 90 days (CHAMPUS Form 190--Exhibit 21). Before a decision was made regarding the extended hospital request a consultation was held with the OCHAMPUS Medical Director, Dr. Alex R. Rodriguez, who is by training a child-adolescent psychiatrist, and is Board certified in utilization review and quality assurance (Exhibit 26). In his peer review, Dr. Rodriguez found the initial evaluation and treatment of the patient's somatic and psychiatric conditions was medically necessary, but it was his opinion that after the 90th day, the care could reasonably have been provided on an outpatient level of care. He noted the medical notes in the record between May 23rd and August 11th show some shoulder pain, allergic problems and psychological problems, but he felt they could have been managed on an outpatient basis and concluded: "In

fact, his psychiatric problems may have been better managed with intensive outpatient (family, individual) psychotherapy closer to home" (Exhibit 26, page 2).

On the basis of the material in the record and this medical opinion, benefits beyond 90 days of inpatient hospitalization were denied as above the appropriate level of care and not the treatment of choice (Exhibit 27). The Hospital requested a hearing by letter dated April 26, 1983 (Exhibit 28). It appears they were notified by phone that because a Formal Review Decision had not been made, they had no right to a hearing at that time.

A letter was then received from Ms. Israeli of the Hospital accounting office (Exhibit 30) and attached to it was a memorandum from Dr. Miller to the Utilization Review Committee dated April 4, 1983 regarding the beneficiary. He described the patient as having been previously treated at National Asthma Center in 1977 and 1978, and after he returned home he did well for approximately six to nine months but then "began to show frequent episodes of breakthrough wheezing requiring numerous emergency room visits and hospitalizations." The report stated that in the six months prior to his admission for this hospitalization, "He had attended school only ten times, and was clearly not complying with medical treatment. The referring physician as well as other mental health and support persons indicated that significant family and emotional problems were affecting 's condition, but they were unsuccessful at intervening in an effective manner. He was therefore referred for inpatient treatment at National Jewish Hospital" (Exhibit 30, page 4). This memorandum describes his hospital course as follows:

> "The patient spent the first five weeks of the hospitalization on the pediatric floor. During this time, his asthma was quickly and easily brought under control. Significant emotional and family problems were noted by the pediatric fellow and social worker, and a psychology consult was obtained. The findings indicated that the patient was extremely comprised in his psychological functioning (in part related to the serious family problems from which he had come), that his learning capabilities were significantly limited. It was felt that his noncompliance with self-care and medication were maladaptive attempts to reach out for help, and maintain cohesion within his family. He was transferred to the pediatric psychosomatic unit (2 May) for treatment (estimated at four months) of the following problems; (1) moderate to severe depression, (2) noncompliance with medical treatment, (3) learning disabilities, (4) low self-esteem, (5) unstable family situation."

He described the patient as upset and tearful, especially when talking about his family, problems with sleeping, frequent somantic complaints, poor appetite, poor impulse control and frustrated, and engaging in frequent fighting. Dr. Miller describes the treatment as intense psychotherapy (average two times a week). He reports the symptoms gradually responded and the patient was

"greatly improved at the time of discharge, being able to experience his feelings and express them more openly, and exhibiting little to no behaviors of or self destructive nature."

The unstable family situation with which the patient was confronted was felt to contribute significantly to his problems with asthma. Dr. Miller states: "During the time of treatment at National Jewish Hospital, this writer maintained close contact with the family, home support persons, and referring physician. Issues were addressed directly with the family and treating persons, and the relationship between the parents problems and 's poor asthma management were outlined. Parents were strongly urged to get counseling, and this was supported and effected by the social worker in their home community and their referring physician. At the time of discharge, plans were in place for ongoing counseling and family therapy for and his parents." In his summary, Dr. Miller stated: "Although the problem with the family is likely to remain somewhat unstable, will be much more able to effectively deal with these circumstances as a result of his treatment at National Jewish Hospital."

This memorandum from Dr. Miller was submitted to Dr. Brenner of the Utilization Review Committee, who also wrote a memorandum to Mrs. Israeli of the patient business office on July 28, 1983. Dr. Brenner states that after reviewing the chart and discussing the patient with Dr. Miller and reviewing his memorandum discussed above: "We concur with his justification regarding 's admission. This patient had multiple psychological problems, which directly impacted on his asthmatic condition, and rendered him refractory to routine outpatient therapy. This was the second admission for the child at NJH/NAC and it was the impression of his referring physicians, both pediatricians and allergist in Fort Campbell, Kentucky, that he required a long-term stay on our pediatric psychosomatic unit, with concommitant medical and psychological and educational assessment and treatment in order to function" (Exhibit 30, page 2).

After receiving these memoranda a case conference was again held with the OCHAMPUS Medical Director (Exhibit 31). In his report, Dr. Rodriguez felt there was "an inadequate level of evaluation of this child's psychiatric condition. He was being evaluated and treated by social worker's and psychology interns. To have stated here that he had a moderate to severe depression was not substantiated by the record or by the diagnosis, adjustment disorder with mixed disturbance of emotion and conduct. I am not aware of any significant diagnostic studies that were done to indicate whether in fact this was a biologically-mediated depression and certainly there was not a professional level of care such as a trained child psychiatrist could provide that would allow for the adequate evaluation of this child in the inpatient setting." Dr. Rodriguez stated in his report that he was not taking the position the patient did not benefit from this program, but he stated: "I will contend that the treatment was not active enough and, therefore that the level of care was not in keeping with the standards of medical psychiatry in this country and there was not enough adequate collaboration with his family." He stated it was imperative that the family be involved in the treatment process for such long-term therapy to be medically necessary.

The Formal Review Decision was issued January 24, 1984. In this Decision the first 90 days of inpatient hospital care was allowed, which covered the period from admission on February 22, 1982 through May 23, 1982, but care from May 24 through discharge date of August 11, 1982 was denied as not medically necessary and above the appropriate level of care. A hearing was requested by the hospital on February 21, 1984 (Exhibit 33). A hearing was held on June 25, 1984 before OCHAMPUS Hearing Officer Hanna M. Warren, Ms. Leslie Israeli, Patient Account Supervisor, Mr. Ed Prange, Director of Patient Business, and Bruce Miller, M.D. The hearing was held in the second floor conference room, Building 222, Fitzsimmons Army Medical Center. Mr. Gary Fahlstedt attended the hearing representing OCHAMPUS.

ISSUES AND FINDINGS OF FACT

The primary issues in dispute are whether the care provided to the beneficiary was medically necessary and at the appropriate level pursuant to CHAMPUS Regulation DoD 6010.8-R. Secondary issues that will be addressed are related care and burden of evidence.

Chapter 55, Title X, United States Code, authorizes a health benefits program entitled Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Department of Defense Appropriation Act of 1979, Public Law 95457, appropriated funds for CHAMPUS benefits and contains certain limitations which have appeared in each Department of Defense Appropriation Act since that time. One of the limitations is that CHAMPUS is prohibited from using appropriated funds for "...any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury or body malfunction as assessed or diagnosed by a physician, dentist, or clinical psychologist..."

Department of Defense Regulation DoD 6010.8-R was issued under the authority of statute to establish policy and procedures for the administration of CHAMPUS. The Regulation describes CHAMPUS benefits in Chapter IV, A.1 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, other authorized institutional providers, physicians and other authorized individual professional providers, as well as professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment."

Chapter II of the Regulation, Subsection B. 104, defines medically necessary as "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." Chapter II, B. 14, defines appropriate medical care in part as "That medical care where the medical services performed in the treatment of a disease or injury are in keeping with the generally acceptable norm for medical practice in the United States," where the provider is qualified and licensed and "the medical environment where the medical services are performed is at the level adequate to provide the required medical care." Chapter IV, paragraph G provides in pertinent part: "In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other Chapters of this Regulation, the following are specifically excluded from the CHAMPUS Basic Program:

> 1. Not Medically Necessary. Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury...
>
> 3. Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care...
>
> 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."

Chapter IV, B, specifically covers institutional benefits and provides scope of coverage and exclusions. The requirement of care rendered at an appropriate level is repeated in paragraph (g): "Inpatient: Appropriate Level Required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment..."

Chapter IV.E. provides special benefit information and in paragraph 13 discusses domicillary care as follows:

> "Domiciliary Care. The statute under which CHAMPUS operates also specifically excludes domiciliary care. This is another area that is often misunderstood by beneficiaries (and sponsors).
>
> "a. Definition of Domiciliary Care. Domiciliary Care is defined to mean inpatient institutional care provided the beneficiary, not because it is medically necessary, but because the care in the home setting is not available, is un-

suitable and/or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

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

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

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

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

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

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

It was Dr. Miller's position at the Hearing that this young man was extremely troubled and there were three goals in his treatment of the patient. The first was that he would function at a higher level when he left the hospital than when he came in; that there would be an improvement in the family situation as far as they were able to affect it; and they would provide support systems for the patient and his family at discharge. He testified there was an ongoing study at National Jewish Hospital/National Asthma Center which showed that 11 out of 14 problems of young people who died with asthma are psychosocial or psychological in nature and this is an extremely important aspect of the treatment of children with asthma. The treatment goal was they would try and put together a stable, safe and predictable environment for this young person or try and enable him to function in a healthy way in an unstable environment, or, what usually happens, a combination of the two. Dr. Miller at the hearing went through many of the points in detail in Exhibit 38, which is the Statement of OCHAMPUS position, and addressed himself primarily to the position taken by the OCHAMPUS Medical Director, Dr. Rodriguez, at the time of the peer review. Many of these specific points will be addressed by me in my discussion of the rationale for my decision.

There are some issues I would like to clarify before I begin my discussion. As Mr. Fahlstedt stated at the close of the hearing, there are several things which are not in question. One of them is Dr. Miller's credentials even though there might be some indication that was the case in the report of Dr. Rodriguez. As I explained to Dr. Miller at the hearing, in going through the hearing file it was unclear to me what his training was other than being an M.D., as there was nothing in the file to indicate he was a Board Certified general and child psychiatrist. It is possible Dr. Rodriguez shared that same concern, but Dr. Miller's qualifications and credentials are not now in dispute, if they ever were.

Another point not in dispute is the motivation of Dr. Miller and the entire hospital staff in treating this young man. At the hearing Dr. Miller described himself as [redacted]'s advocate and his first thought was what was best for [redacted]. That is clear, both in the file and in his testimony at the hearing, and certainly no one is questioning his decision to continue this hospitalization for five and a half months. My decision is not whether the hospitalization was proper or that the patient benefited from it. My decision concerns only whether this is the type of care for which CHAMPUS benefits can be extended. CHAMPUS is not an insurance program, it is a benefits program. It is authorized by Congress and the enabling legislation contains certain restrictions on coverage, as does the implementing Regulation which has the force and effect of Federal law. These specific restrictions are binding upon me as Hearing Officer, upon the beneficiary and his sponsor, and upon the provider furnishing care. CHAMPUS is an "at risk" program where medical services are supplied, claims are submitted for those services and a determination made as to whether the services are a covered benefit under the CHAMPUS law and Regulation.

The third point made by Mr. Fahlstedt in his closing statement that was not in dispute was that the initial hospitalization was appropriate. The Medical Director has found that to be the case and I agree, although as Hearing Officer I do have some problems with the documentation for the kind and type of care that was being provided on the 2-May unit. At the hearing Dr. Miller made reference to Dr. Rodriguez' discussion of the need for inpatient hospitalization on page 2 of Exhibit 31. I agree with Dr. Miller that in this second paragraph the sentence, "To say that an inpatient level of care was indicated, I will waive to that contention and say that I think he should have been hospitalized" could have been more exact. I believe that, taking it in the context of the other discussion by Dr. Rodriguez, what he is referring to is the initial hospitalization. A correct interpretation might be that he would have preferred even the initial hospitalization to be closer to the patient's family so that family involvement could have commenced immediately and thereby, in his opinion, shortening the hospital stay.

I have reviewed the entire record, including the additional exhibits brought by Dr. Miller to the hearing, and I believe it is fair to say that, although this young man had been hospitalized and/or treated for his asthma when at home at least every two weeks, missed considerable school, was abusing his medications, etc., his condition improved almost immediately upon admission to the hospital, and his asthma condition remained stable throughout the period of hospitalization. Dr. Brenner described his asthma as "eminently controllable" (Exhibit 3) and Dr. Miller stated his asthma was "quickly and easily brought under control" (Exhibit 30). Although he was monitored by the staff, the record does not contain any material showing his continued hospitalization beyond ninety days was necessary for the medical treatment of his asthma.

The record does indicate that at the time of the patient's transfer to the 2-May unit on March 30, 1982, it was anticipated he would remain there for a period of two months. There are several references to this in the record and a letter from the Social Worker dated March 24, 1982 states: " will be transferred to our long term program for approximately 2 months to allow time for the most effective post-discharge therapy we can arrange" (Exhibit 44). This initial projection seems to have been changed to four months around the last of May. It appears the family situation had deteriorated at that time and I can understand the reluctance of the staff to return the patient who had been doing so well to this difficult family situation, but the CHAMPUS Regulatory provisions contain restrictions on coverage of long term hospitalization and require documented medical necessity for care to continue at that intense level of care.

There are several preadmission forms in the file which show what a distressful family situation in which this young patient was living and, even as a lay person, it is clear that he needed some psychosocial assistance in dealing with this extremely sad and unstable family situation. Two months have been allowed and I have carefully examined the record to consider what documentation is available showing medical necessity requiring another 2 months of inpatient hospitalization. At the hearing Dr. Miller presented Exhibit 40 (a medical evaluation preadmission form) in which the referring physician had checked that

the patient was severely depressed. I would note that he has checked "no" to all the other questions and must add there is no alternative given as to the severity of the depression. The hearing file does not contain the chart or any medical notes for the initial month of hospitalization showing that any psychological/psychiatric treatment was given to the patient. Dr. Miller brought some additional pages of notes to the hearing but the first note by a psychiatrist was by Dr. Miller on the 31st of March, 1982, which was the psych transfer note. In this Dr. Miller states he reviewed the chart and saw the patient for approximately half an hour. I feel some concern that over a month went by from the patient's admission before any psychiatric treatment was started to assist this patient to deal with the very real problems he had. If the patient were severely depressed, it seems reasonable to expect that some kind of psychiatric intervention would have been started immediately since Dr. Miller was on the staff and available. In the psych transfer note, Dr. Miller states "His mood did appear to be anxious and mildly depressed and his affect was constricted". The chart indicates that was seen some time during March by the clinical psychologist for purposes of evaluation with her report March 30th. She described the patient as "mildly depressed."

I agree with Dr. Miller's statement that the patient needed assistance in dealing with his tragic and unstable family situation so that he could control his asthma. That is clear. The problem is the treatment that was provided and the concerns during this lengthy period of hospitalization are not clear and this in some part is due to lack of notes in the medical record. At the hearing Dr. Miller said he felt there were some things that were not included in the record and he had gone through the entire medical file and had copied the ones he felt were relevant and important. I admitted those notes as exhibits and have considered them for purposes of this decision. While the patient was in a very intense, and expensive, inpatient hospital acute care setting, the notes kept on this patient are minimal. Although Dr. Miller supervised the milieu therapy, acted as the team leader and additionally saw the patient two times a week for individual psychotherapy, there are only nine notes written regarding this treatment. In reading all of them they tend to be fairly similar in content, mostly referring to the parents' illness and the family's inability to deal with the patient's needs. The format in the April 16th, 1982 note is the usual one; which essentially states what treatment was being rendered, individual therapy, etc., and the goals, which remained fairly constant throughout. The actual description of the treatment process, the patient's reaction and psychiatrists' impressions are minimal. One reference is made to a lengthy conference with the mother but there are no notes as to what occurred. A concern is shown about discharge planning on the part of Dr. Miller and some phone contacts are referred to with the parents and the social worker at the referring institution as to what care and treatment would be available to the patient after discharge.

There are notes written by the counsellor in the chart and also notes of the social worker concerned primarily with a chance to find a placement and resolve this young man's family situation. Dr. Miller testified at the hearing that the active involvement of the social worker was perfectly acceptable medical procedure in a psychiatric hospitalization, especially with children, and he

took issue with Dr. Rodriguez' statement there was inadequate psychiatric involvement in this case. Again, I have no problems with Dr. Miller's statement that involvement of the social worker and counsellor was appropriate for inpatient care of this young man, especially in view of the fact that one of the goals from the beginning that is clear to anyone reading the record must be to try and achieve help for the mother and father and improve and stabilize that situation as far as possible. It was obvious to everyone from the very beginning of treatment there needed to be some type of family therapy initiated and some help available to this family when the patient was discharged, whenever that discharge date would be.

The Department of Defense Appropriations Act 1979, Public Law 95-457 prohibits the use of CHAMPUS funds for "any service or supply which is not medically or psychologically necessary to prevent, diagnose or treat a medical, mental or physical illness, injury or bodily malfunction as assessed or diagnosed by a physician and a clinical psychologist." This restriction, as discussed above under the law, has consistently appeared in each subsequent Department of Defense Appropriations Act and is further defined in the Regulation quoted above. Under these statutory and regulatory provisions the inpatient care in question must be found to be medically necessary and essential for the care and treatment of a specific diagnosed condition. I have concluded that the continued inpatient hospitalization of the beneficiary beyond ninety days was not medically necessary for treatment of his asthma, per se, but was directed toward psychosocial treatment which, of course, would impact on his asthma. I also find the record does not document he was retained in the hospital because of concern or treatment for his depression. There is very little in the record, other than routine mention, which was described by both Dr. Miller and the psychologist as mild at the beginning of his hospitalization. By the June 18th psych note the patient's depression had "dramatically improved."The other diagnosis given by Dr. Miller was adjustment disorder with mixed disturbance of emotions and conduct (reactive depression) (Exhibit 30). Exhibit 47 is the description of adjustment disorder from DSM III, 3d Ed., February, 1980. I have read the description and it appears to be applicable to this beneficiary and again I want to stress that I am not deciding that psychological social factors do not have an important impact on this patient's asthma. I believe that to be the case and it is well documented in the file. What I must decide is whether the adjustment disorder mandated continued hospitalization for treatment and the record does not support the position that it was medically necessary.

A careful examination of the record leads one to speculate that if the parents had not been having a marital flare up at the end of May, the patient would have been discharged at that time as originally anticipated. There is reference to a conference held prior to the May 27th psych note in which the decision was made for continued hospitalization. There are no notes of this conference in the record. Based on available documentation, I must conclude that the patient was kept an additional seventy-five days to allow the family situation to improve and as Dr. Miller testified, to assist the patient in dealing with the family situation in case it did not improve. Given the clear constraints of the CHAMPUS law and regulation, I do not find the acute

hospital inpatient setting was medically necessary for treatment of the patient beyond the end of May. The record shows that the patient's condition at that point was such that alternative treatment could have been considered. Dr. Miller expressed concern at the hearing, which is also documented in the record, that the patient's family was resistent to psychiatric treatment and had not followed through after the patient's previous hospitalization, complicated probably by having some unfortunate experiences with the social worker. That is an unfortunate situation but cannot be the basis for continued in patient acute care. If it was not feasible for the patient to return home, other types of care could have been provided, including a residential treatment center or foster home, assuring that the patient would receive treatment on an outpatient basis. In addition there was one resource at Fort Campbell that had not been there previously when the patient was discharged and that was Dr. Tony Bunker-Soler who had been a Fellow at National Jewish Hospital and was presumably more aware of psychosocial factors in the treatment of asthma and more able to facilitate follow-up treatment and counseling. The record indicates that when the patient was discharged from the hospital, Dr. Bunker-Soler took over his primary care.

Dr. Rodriquez felt very strongly that appropriate care for this patient after the first ninety days would have been care provided closer to the patient's home so the family could have been involved, and the record supports this contention. I realize that Dr. Rodriquez had not seen the patient and I have taken that into consideration, but the records kept contemporaneously with the care by the people who were seeing the patient do not document that an acute level of care was necessary or that medically necessary care could only have been provided by a facility such as National Jewish Hospital. The opinion of the medical director was that a medically necessary effective treatment of this patient would be to involve his family in the treatment process. This was also the original treatment plan but the record shows it was clear after two months, this was not going to happen with the patient in Denver and the family in Kentucky. My experience as a hearing officer in cases involving disturbed adolescents who suffer from a more severe psychiatric illness than this patient is that the primary concern of the treating personnel has always been to involve the family members to the greatest extent possible. I realize this patient's family had shown little interest in being involved in his treatment and there were certain elements to this family situations over which there could be no change, such as severe physical illness. But it seems clear the family was not interested in being involved and with the patient so far away, it was easy to not have to get involved. This indicates that while this young man may have required some treatment, inpatient care so far from his family was not an appropriate level of care. Even the article brought to the hearing by Dr. Miller (Exhibit 42) discussing behavior modification states "It is not in the child's best interest to misuse the hospital and be away from family, friends and school."

The CHAMPUS Regulation defines appropriate medical care as treatment "in keeping with the generally acceptable norm for medical practice in the United States." Dr. Rodriguez in his peer review stated that long-term hospitalization away from family involvement was not in keeping with the

generally accepted norm for treatment of adolescents and there was no authoritative medical research showing that long-term care on a unit such as 2-May is medically necessary or efficacious in treating young people such as the beneficiary in this case.

I have also considered the specific CHAMPUS restrictions on care that is determined to be domiciliary care. While I find the care provided in this case to be very close to the definition of domiciliary care, which is excluded from CHAMPUS benefits, I do not find the provisions of this exclusion to be totally applicable to the facts of this case. The patient did need additional treatment, as did the parents, until some of the family conflicts could be resolved. While the care comes very close to being provided for the convenience of his family or because there was not a home for him to go to that was appropriate, I am not basing my decision on the specific exclusion for domiciliary care.

SECONDARY ISSUES
RELATED CARE

Although the amount in dispute involves all hospital charges including charges for the attending physicians I do want to point out that Chapter 4, G.66 of the Regulation excludes from CHAMPUS coverage all services and supplies related to a non-covered treatment or condition. Because I found that inpatient hospitalization after ninety days was above the appropriate level of care and thus not medically necessary under the CHAMPUS law and regulation, all related care after that time, including that of the treating physician, is also not covered.

BURDEN OF PROOF

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 can to overcome the initial adverse decision. I have concluded that the appealing party has not met this burden and while inpatient care may have been the treatment of choice, it is excluded from coverage under the CHAMPUS law and regulatory provison because it was above the appropriate level to provide medically necessary care.

SUMMARY

It is the recommended decision of the hearing officer that inpatient hospitalization and all related medical care from February 22, 1982 through May 22, 1982, should be cost-shared by CHAMPUS as it was medically necessary care and rendered at the appropriate level, but all care from May 23 through August 11, 1982, was above the appropriate level for medically necessary care and should be denied CHAMPUS coverage.

DATED this 13th day of August, 1984.

Hanna M Warren

HANNA M. WARREN
Hearing Officer