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	)	
	)	OASD(HA) File 84-36
Sponsor:	)	FINAL DECISION
	)	
SSN:	)	

This is the Final Decision of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-36 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party in this case is the beneficiary, the 15-year-old son of an active duty officer in the United States Navy. The beneficiary was represented in this appeal by his father and two attorneys.

The appeal involves the question of CHAMPUS coverage of inpatient psychiatric care provided the beneficiary from November 6, 1980, to March 8, 1981. The total hospital charge incurred by the beneficiary for these dates was $32,771.05 which represents the inpatient hospitalization and psychiatric treatment at Barclay Hospital, Chicago, Illinois. The attending psychiatrist's services totalled $8,265.00 in charges. The CHAMPUS Fiscal Intermediary denied CHAMPUS coverage after January 6, 1981, because the hospitalization and inpatient services were above the appropriate level of care and not medically/psychologically necessary. Because CHAMPUS has agreed to cost-share the first 60 days of hospitalization, the amount in dispute is approximately $20,017.80.

The hearing file of record, the tapes and oral testimony 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 CHAMPUS coverage for inpatient care and professional services from January 6, 1981, to March 8, 1981, be denied because it was above the appropriate level of care and not medically/psychologically necessary. The Director, OCHAMPUS, concurs in the Recommended Decision and recommends its adoption as the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs).

The Assistant Secretary of Defense (Health Affairs) after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer to deny CHAMPUS payment for

care and services rendered from January 6, 1981, to March 8, 1981, and hereby adopts the recommendation of the Hearing Officer as the FINAL DECISION. The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to approve CHAMPUS coverage for inpatient care for psychiatric hospitalization for evaluation purposes from November 6, 1980, through January 5, 1981, and to deny CHAMPUS coverage from January 6, 1981, through March 8, 1981. The decision to deny CHAMPUS coverage for care from January 6, 1981, through March 8, 1981, is based on findings that such care was above the appropriate level of care and not medically/psychologically necessary.

FACTUAL BACKGROUND

This 15-year-old beneficiary was hospitalized by his parents in Barclay Hospital, Chicago, Illinois, on November 6, 1980. The patient's history, as described in the hospital records and related by the parents, included severe acting out behavior since age 5, verbal and physical aggression, failure and truancy in school, failure to abide by any limits set by his parents, association with negative peer groups, community vandalism and thefts, and reported alcohol and drug abuse. Previous treatment reported in the record included family therapy in lieu of detention as a result of setting fires at school and in a school bus. In addition, as a result of the theft of a mo-ped bike in July 1980, the beneficiary was referred for outpatient therapy through the police department. On November 6, 1980, the parents sought psychiatric hospitalization because the beneficiary became unmanageable at home. The attending psychiatrist, by subsequent letter dated July 28, 1981, reported that the beneficiary's previous treatment ". . . had failed to change his behavior, which was rapidly deteriorating. It was necessary then, for his own protection, to have him hospitalized as the least restrictive alternative."

The psychiatric examination report submitted November 7, 1980, contains the following comments regarding the beneficiary's mental status:

> ". . . appeared appropriate in his dress and appearance upon entering the hospital. He seemed mildly anxious and uncertain about himself. [He] admitted that he was feeling quite uncertain about his present situation and had very mixed feelings with respect to entering the hospital program, nonetheless, he did indicate that he felt that it was appropriate because of the amount of difficulties he was experiencing at home.
>
> "In general, his affect appeared depressed and somewhat flat.
>
> "In general, his association appeared logical and coherent. He gave no evidence of

> delusional or obsessional type thinking. He denied persistent suicidal ideation, although he indicated at times that he has thought about suicide as a way of 'getting even' with his parents or possibly making them feel bad. He denies any actual suicide attempt.
>
> "[He] appeared oriented as to person, place and time. He gave no evidence of any type of faulty or unusual preception or distortion of reality. He denied hallucinatory activity although he admitted he is afraid he is unsure of certain sounds and noises in his environment.
>
> "[He] appears to be functioning within at least the Average Range of intelligence. . . .
>
> ". . . [He] admits that he has no insight into his behavior with respect to the tensions and conflicts at home. He feels confined and is seeking some outside assistance and directions. He admits he has been getting into trouble and making inappropriate decisions which lead to continuing conflict and problems within the family."

The psychiatrist diagnosed the beneficiary as having Major Affective Disorder-Other and recommended admission to the second floor Adolescent Program at the hospital with placement on "orientation level and usage precautions until he feels comfortable in the program. He will be seen in daily group therapy as well as individual therapy. He will be assessed for activities therapy and for fall school program while hospitalized . . . [he] will be given a full psychological diagnostic evaluation."

The Social Assessment report prepared on November 17, 1980, after reviewing the patient's personal and family history, noted that: "Family therapy will be an important part of treatment as the family explores the patterns of behavior that have been established over a number of years and the purpose these behaviors serve. Careful assessment of progress in family therapy is essential before planning post-hospitalization treatment for [the patient] because alternatives to his returning home may need to be explored."

On November 19, 1980, the following tests were conducted: Wechsler Intelligence Scale for Children-Revised, Wide Range Achievement Tests, Bender/Gestalt Test, Draw-a-Person, Kinetic Family Drawing, Rorschach, Thematic Appreciation Test, and Rotter Incomplete Sentence Blank. When interviewed by the testing psychiatrist it was observed that the beneficiary related in a

quiet, compliant, but sometimes anxious and passive/aggressive manner. He was oriented in all spheres, and his thought processes were logical and coherent. In the opinion of the evaluating psychologist, the projective tests indicated "considerable and consistent evidence of significant emotional and psychosexual conflicts which are not particularly amenable to conventional psychotherapy."

The psychological evaluation report contained the following summary and recommendations:

> "[The patient] appears as a youngster of at least average intellectual potential, although he has been failing in school and underachieving for a significant period of time. There is no clear indication of any underlying disability or organic dysfunction. Projective test responses indicate a very frustrated and depressed individual with significant psychological conflicts. [He] appears to be dealing with his anger through behavioral acting out, paranoid distrusting attitudes and excessive use of projection and denial.
>
> "1. [He] is currently in need of intensive intervention in order to prevent further deterioration in his behavior and because he admits periods of confusion and panic which seem stimulated by his self-destructive impulsiveness.
>
> "2. [He] admits to significant unhappiness and tension in the family interactional patterns and these must be explored and addressed in family therapy sessions.
>
> "3. At this time it appears that the behavioral maladaptive defense system developed by [him] to deal with his depression and conflicts is quite entrenched. Consequently, it would appear that it may be necessary that placement in a long term structural setting away from the family interactional patterns may be necessary for the application of [his] intellectual potential and obtainment of reasonable academic goals."

In a letter dated July 13, 1981, the attending psychiatrist listed the final diagnosis (DSM III) as:

> "Axis I: Atypical Depression 296.82
> Identity Disorder 318.82

"Axis II: Overanxious Disorder of
Adolescence 313.00
Conduct Disorder, Socialized,
Unaggressive."

The attending psychiatrist also identified the modalities of treatment as including "individual therapy five times a week, group therapy, activity and recreational therapy, milieu therapy with the school program as an integral part of the total treatment plan."

The Discharge Summary prepared on March 9, 1981, indicates the patient was seen at least five times a week by the hospital's psychologist and at least three times a week by the attending psychiatrist. The family was seen nearly on a weekly basis by the psychologist and hospital social workers.

Weekly progress reports were kept on the beneficiary. It was opined in the first week's report that the sponsor "is extremely invested in the Court protecting his son and this appears to be the reason why there has not been any direct policy action on much of [his] delinquent behavior. . . . At this time, estimated length of hospitalization appears to be from 60 to 75 days." Each weekly progress report contains, in general, the following information and opinions of the attending psychiatrist and psychologist: a statement of the continued need for hospitalization; specific incidences concerning the conduct and behavior of the beneficiary; the need to have the patient "timed out from group activities or school programs or, on other occasions, placement of the patient in leather restraints; the frequency of meetings with the psychiatrist or psychologist; and general opinions regarding the family and the estimated period of hospitalization.

Frequent references were included in the progress reports regarding the family's inability or unwillingness to address the home environment - such as alleged excessive drinking - and the interactional family issues. Finally, in the report dated December 26, 1980, the need for a residential, structured setting after hospitalization based on the breakdown in the family setting was raised. This was reported as upsetting to the father and that he definitely opposed the idea although he indicated he would give it some thought.

Although therapeutic passes for family visits were initiated, the weekly progress reports noted that it was becoming more clear in individual family therapy that conflicts at home were in no way being resolved satisfactorily. During the week of January 9, 1981, it was determined in a family session that "because of [his] evident mounting anxiety, impaired judgment, and impulsive behavior that treatment would probably not be effectively complete within a short hospital stay. Consequently, residential treatment would be requested from the school district at the multi-disciplinary staffing which is scheduled next week." The report for January 16, 1981, indicates that residential

placement was still being recommended, but that placement was dependent on assistance of other state agencies. During the subsequent weeks, the alternatives of residential placement and day school programs were discussed. Finally, on March 8, 1981, the beneficiary was discharged from the psychiatric hospital to residential treatment.

A CHAMPUS claim for 105 days of hospitalization (November 6, 1980, through February 18, 1981) was received by the CHAMPUS Fiscal Intermediary on or about March 13, 1981. A CHAMPUS claim for the remaining 18 days of hospitalization (February 19, 1981, through March 8, 1981) is not in the record; however, documentation in the record indicates the charge for the final 18 days of hospitalization was $4,550.70. The total hospital charge for 123 days of care, then, was $32,771.05.

A CHAMPUS claim for the services of the attending psychiatrists, including psychological testing, from November 6, 1980, through March 8, 1981, was submitted on August 17, 1981. The total charge was $8,265.00.

Pursuant to the Manual for Inpatient and Outpatient Psychiatric Claims Review, OCHAMPUS Manual 6475.1-M, the hospital claim was referred for psychiatric review under the CHAMPUS American Psychiatric Association Peer Review procedures. One reviewer opined that the care was medically necessary, that hospitalization was the appropriate level of care, that the therapeutic program was appropriate for the diagnosis, and that the length of stay was appropriate for the diagnosis and treatment program. The reviewer also commented that he agreed with the recommendation for placement in long-term residential treatment after hospitalization.

The other two reviewing psychiatrists opined that the entire period of hospitalization was not medically necessary. One reviewer recommended partial approval only for 30 days of hospitalization. In his opinion, the description of "family pathology" was an inadequate medical reason for hospitalization. He opined that the hospitalization was not medically necessary and was at an inappropriate level of care. Finally, he opined that the diagnosis of atypical depression was not substantiated; rather, depression was clearly present secondary to frustration at being curtailed from acting out behavior.

The third reviewer commented as follows:

> "I feel that care is medically necessary for an initial psychiatric evaluation, but I feel the questionable part is the length of stay in a psychiatric unit when the evidence indicates little or no progress is being made. I strongly disagree with the diagnosis and feel that the evidence in no way justifies the diagnosis of major affective disorder. It seems to me that the evidence

> is quite clear in substantiating a long standing socialized aggressive conduct disorder, and a substance abuse disorder. In spite of the mention of substance abuse as a significant problem in all of the initial documents concerning history I see no evidence that there were any goals during the therapeutic process concerning education, further evaluation, or stressing of abstinence of drug abuse. In many ways, the evidence in the records is quite typical of adolescent chemical dependency and this issue might well have been considered the primary problem with a primary emphasis on treatment in a chemical dependency program. It is for the above reasons that I highly question the level of care and the nature of the therapeutic program as appropriate for this patient. Because I have so many basic disagreements with a philosophy of care in this type of situation, it is difficult for me to stipulate whether the length of in-patient stay is appropriate or not. If one is going to assume a standard adolescent psychiatric treatment is appropriate, then a 60 day stay is consistent with that usually administered in similar cases, but I would consider any length of stay beyond 60 days as inappropriate. At this point, evaluation should have been complete, assessment of progress should be quite accurate, and a recommendation into a longer term residential setting would probably be the best disposition. The level of care of such a program would not have to be hospital based. In summary, in keeping with a philosophy of acceptance of a wide-range of different treatment orientations for this type of problem, I would recommend approval of the claim for no longer than 60 days of in-patient care."

After receipt of the medical review opinions, the CHAMPUS Fiscal Intermediary on May 18, 1981, denied CHAMPUS coverage of hospital care in excess of 60 days because the hospitalization was not medically necessary after the initial evaluation period. The charge for 105 days of care totalled $28,220.35, and the Fiscal Intermediary allowed $16,243.25 in charges related to the first 60 days of hospitalization. After deducting the patient's cost-share of $5.50 per day ($577.50), a CHAMPUS payment of $15,665.75 was issued. Adding the charge for the last 18 days of hospitalization ($4,550.70), the total denied hospital charge, then, is $16,527.80.

The attending psychiatrist's claim totalling $8,265.00 was paid in the amount of $4,775.00 for the first 60 days of inpatient care. The remaining $3,490.00 was denied as relating to unauthorized inpatient care. The total amount in dispute, then, is $20,017.80.

An informal review of the partial denial was requested by letter dated August 11, 1981. The fiscal intermediary again referred the case for medical review by three different American Psychiatric Association psychiatrists. In summary, the opinions of the three reviewers were that the medical records show possible inconsistent diagnoses; some entries suggest neurotic patterns, but the overall picture is one of character pathology; a more clear, direct, and specific environment experience was preferable to hospitalization; hospitalization may have enhanced the patient's self-importance and delusions that he would be protected and indulged in his violent behavior; the record evidenced dysfunctional behavior which warranted psychiatric evaluation, but the hospital stay was too long considering the lack of clear therapeutic goals or progress; and, residential treatment was considered the treatment of choice.

The Informal Review Decision and the Reconsideration Decision of the fiscal intermediary again denied CHAMPUS coverage of hospital care in excess of 60 days as above the appropriate level required for medically necessary care. The denial was then appealed to OCHAMPUS.

A child psychiatrist with the Associates in Adolescent Psychiatry S.C. (a professional group which included one of the attending physicians), at the request of the beneficiary's father, submitted a letter dated October 20, 1981, in support of the appeal to OCHAMPUS. In his letter, the child psychiatrist identified portions of the medical record which, in his opinion, justified the hospitalization beyond the first 60 days. These include recorded instances in January and February 1981 of regressed behavior, increased anxiety, ambivalence, impaired judgment, and weakening of ego boundaries; the need to place the patient in full leather restraints due to agitated behavior considered potentially harmful to the patient and others on the 66th day of hospitalization; initiation of the individualized daily level system which is used for the more regressed and primitive patients on January 23, 1981; the denial of therapeutic passes in early February due to unstable and unpredictable behavior; and, the continuing difficulties with respect to irritability, moodiness, unpredictability, impaired judgment, and loss of control, all of which were viewed as relevant to the diagnostic problem and specific goals of stabilization of behavior.

In addressing the appeal, OCHAMPUS referred the case for review one more time under the CHAMPUS American Psychiatric Association review system. The reviewing psychiatrist, a Diplomate of the American Board of Psychiatry and Neurology, and Child Psychiatry, opined that, on the basis of a history of

substance abuse, truancy, fire setting, stealing and vandalism, fighting with peers, and aggressive behavior, a more appropriate diagnosis was undersocialized conduct, disorder-aggressive type 312.00; daily psychotherapy has not been particularly helpful in such patients, but a tightly controlled behavioral treatment would be preferred; an improvement after the initial 60-day period was minimal based on the records; continued hospitalization after the first 60 days was not the appropriate level of care for the patient, but a residential center that specializes in the treatment of incorrigible, delinquent boys would be the treatment of choice; and continued psychiatric treatment in a hospital setting was not warranted beyond the initial 60 days.

The OCHAMPUS First Level Appeal Decision upheld the previous decisions of cost-sharing the initial 60-day evaluation period and denying the remainder of the inpatient care from January 6, 1981, through March 8, 1981, because the care was above the appropriate level and not medically/psychologically necessary. A request for hearing was submitted, and a hearing was held by Valentino D. Lombardi, Hearing Officer, on December 14, 1982. The Hearing Officer has submitted his Recommended Decision and all prior levels of administrative reviews have been exhausted. Issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether the inpatient care and related professional services at Barclay Hospital from January 6, 1981, to March 8, 1981, are authorized care under CHAMPUS. In resolving this issue, it must be determined whether the care rendered during this period in issue was medically/psychologically necessary and provided at the appropriate level of care.

Medically/Psychologically Necessary Appropriate Level of Care

The Department of Defense Appropriation Act 1981, Public Law 96-527, prohibits the use of CHAMPUS 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 bodily malfunction as assessed or diagnosed by a physician, dentist, clinical psychologist, optometrist, podiatrist, certified nurse-midwife, or, for the purpose of conducting a test during fiscal year 1981, by certified psychiatric nurse, other certified nurse practitioner, or certified clinical social worker, as appropriate, . . ." A similar restriction has appeared in all Department of Defense Appropriation Acts for subsequent fiscal years.

The CHAMPUS regulation, DoD 6010.8-R, is consistent with the funding restriction and provides in chapter IV, A.1., in part that:

> "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 . . ."

The regulation defines "medical necessity" in chapter II, B.104., as:

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

The requirement of appropriate level of care for CHAMPUS coverage is also set forth in DoD 6010.8-R, chapter IV, B.1.g., which provides, in part, that:

> "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."

To remove all doubt about the CHAMPUS requirement, DoD 6010.8-R, chapter IV, G.3., specifically excludes all "services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care."

Finally, DoD 6010.8-R, chapter II, B.14., defines "appropriate medical care," in part, as:

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

The appealing party contends that the decision to deny CHAMPUS coverage of the beneficiary's inpatient care in an acute psychiatric hospital beyond the initial 60-day stay is in error because of an alleged failure to adequately review the medical records and failure to apply the appropriate review standards. It is argued by the appealing party that a thorough review of the records would result in a finding of specific therapeutic goals including the type of treatment necessary to meet these goals and the expected date of attainment of the goals. In addition, two expert witnesses testified at the hearing in support of the medical necessity of the beneficiary's full 123-day

hospitalization. One witness, a psychologist at Barclay Hospital, referenced the beneficiary's uncontrollable behavior after the initial 60-day hospital stay and indicated the beneficiary was not ready for any lesser type facility. He stated the patient was resistant to treatment, was sociopathic in behavior, and uncontrollable.

The second witness, a psychiatrist and president of Associates in Adolescent Psychiatry, was one of the attending physicians (although not the primary attending psychiatrist) for the beneficiary during his hospitalization. He stated that discharge prior to March was not appropriate in view of the time necessary to prepare the beneficiary for adjustment to another placement. He was very firm in his convictions, stating his belief that the patient or someone else might have been dead had the beneficiary been discharged earlier. He described the patient as a treatable child who suffered mental illness serious enough to be considered a handicap; that he had specific learning disabilities which were a manifestation of his mental illness; and that the inpatient treatment allowed him to overcome these problems through various multiple services.

Both witnesses stated the initial length of hospitalization was indicated as between 60 and 75 days. However, due to lack of improvement and a change of goal from home living to residential treatment care, the length of stay was increased. Both witnesses opined that the patient should have been hospitalized longer than the 123 days, but was discharged to residential treatment care due to outside family pressures. The witnesses indicated that following residential treatment placement the patient initially ran away but returned and made a substantial recovery.

The beneficiary's father also testified at the hearing that the extended hospitalization was necessary because his son was still "out of control." The father noted improvement in his son and believed his son a changed man, crediting the additional 2-month inpatient stay with saving his son's life.

As noted by the Hearing Officer, the case file and the hearing testimony established the firm conviction of the experts on either side of the issues involved in this case regarding the proper mode of treatment of the beneficiary. While the appealing party contends the record supports the medical necessity of the treatment, the CHAMPUS medical reviewers, with one exception, basically concluded that the beneficiary's hospital stay was far too long based upon his symptoms and diagnosis. The majority of reviewers even disagreed with the reported diagnosis of the beneficiary.

After evaluating all of this evidence, the Hearing Officer noted that, given the sharply divided opinions regarding the beneficiary's level of care, the recommendations for placement were similar if not the same by all the experts. That is, all evaluations finally determined that residential treatment placement was appropriate. As defined in DoD 6010.8-R,

chapter II, B.155., such a facility provides "round-the-clock, long-term psychiatric treatment of emotionally disturbed children who have sufficient intellectual potential for responding to active psychiatric treatment, for whom outpatient treatment is not appropriate and for whom inpatient treatment is determined to be the treatment of choice." The beneficiary was eventually discharged to residential treatment and according to the attending psychiatrist's testimony at the hearing, the beneficiary made a substantial recovery.

The Hearing Officer concluded, and I agree, that the resolution of the issue of medical necessity and appropriate level of care depends upon the question as to the time when discharge to residential treatment was appropriate.

Under the cited statutory and regulatory provisions, the inpatient care in question must be found to be medically necessary (essential) for the care or treatment of a diagnosed condition. A thorough review of the hearing file of record leads me to conclude that hospitalization for the period of January 6, 1981, to March 8, 1981, was not medically necessary in the treatment of this patient. Those medical reviewers who opined that the care beyond 60 days was not medically necessary, did so based upon little or no progress being made after the initial 60 days, disagreement with the diagnosis, absence of goals during the therapeutic process concerning education and evaluation, and the absence of documented signs and symptoms to justify care in an acute psychiatric facility. I agree with the medical reviewers. It appears the patient was in need of long-term care, but not in an acute psychiatric hospital after the initial 60-day evaluation period. The Hearing Officer summarized the record on this matter, in part, as follows:

> ". . . In reviewing the hospital record, careful consideration is given to Exhibit No. 9, page 6 "Social Assessment" wherein the recommendation by the clinical services department on November 17, 1980, only 11 days after the beneficiary's admission to the hospital, was that alternatives to his returning home may need to be explored after an assessment of family therapy. Also on page 10 of said exhibit, entitled "Psychological Evaluation" wherein on November 19, 1980, only 13 days after his admission, the Registered Psychologist and School Psychologist indicated that it would appear that it may be necessary that placement in a long-term structured setting away from the family interactional patterns may be necessary for the application of the patient's intellectual potential in obtainment of reasonable academic goals.

"It is also noted that not until January 9, 1981, in the Weekly Psychologist Summary Report is there a mention of probable placement in a Residential Treatment Center. (Exhibit 5) Although on December 30, 1980, in the discharge planning portion of the Summary, the Attending Psychiatrist was awaiting or expecting changes to occur at home. (Exhibit 6) Evidentally such changes still created a problem, for on January 10, 1981, another Summary indicates that residential treatment is being sought. (Exhibit 6)

"At the time of the beneficiary's admission, the psychiatric examination performed on November 7, 1980, concluded that hospitalization was the least restrictive alternative treatment at that time. (Exhibit 9 page 16) Testimony at the Hearing from the expert witnesses concluded initially that unification with the family was the ultimate goal but this was changed some time during the month of January. It would appear from the records that problems with such an initial discharge plan, that is unification with the family, were apparent even within 11 - 13 days after the beneficiary's admission. Why it took so long to formulate a new discharge plan when the record indicates the problems with the beneficiary during this time from November, 1982, to January, 1981, [sic] is questionable. Whether there were problems with the parents' intervention which is very apparant [sic] even up to his eventual discharge in March, 1981, or whether there was an adequate diagnosis of the problem are unknown, but the majority of the experts who reviewed the file and hospital record evidently discovered these problems and recommended only a 60 day hospital stay.

"The physicians at Barclay Hospital are very competent and steadfast in their determinations; however, the rules and regulations of the CHAMPUS program require the necessity of adequate documentation and proof of the need for medical services. The sponsor has failed to meet the burden of proof necessary to adequately establish the appropriate level of care as required in medically necessary treatment of the beneficiary in excess of 60 days."

Based on the above, the Hearing Officer found the beneficiary's hospitalization from January 6, 1981, through March 8, 1981 to be above the appropriate level of care. I agree and adopt the Hearing Officer's finding and recommendation as the FINAL DECISION in this case.

SECONDARY ISSUES

Determination of Medical Necessity

At the hearing and in the Position Statement submitted by counsel for the appealing party, the issue of who is the appropriate individual to determine medical necessity - the attending physician or a medical review body established under the auspices of OCHAMPUS - was challenged. In regard to this issue, counsel for the beneficiary noted a line of cases from the state courts of New York and Illinois. The decisions in these cases held that the attending physician is the appropriate party to determine medical necessity; not a peer review group. These cases are not applicable to CHAMPUS. In these cases the plaintiff is suing an insurance company because medical benefits were denied after medical review of the care in question. These cases turn on the contractual relationship of the beneficiary to the insurance company. The relationship between CHAMPUS beneficiaries and Department of Defense is administrative and governed by law and implementing regulations issues by the Department of Defense, not by contract.

Counsel for the sponsor implies that because the cited cases hold that the attending physician is the appropriate individual to determine medical necessity, CHAMPUS should also follow these cases by honoring the decision of the attending physician and not submit these decisions to medical review. It is important to note that the requirement that the care be medically necessary is a condition which has consistently appeared in Department of Defense Appropriation Acts involving funds for CHAMPUS and in the administrative regulations implementing the statutory provisions establishing CHAMPUS.

As noted by the Hearing Officer: ". . . Section D of Chapter I of the CHAMPUS regulation, specifically states that CHAMPUS is not subject to those state regulatory bodies or agencies which control the insurance business generally. True, that the weight of authority usually suggests that discretion rests with attending physicians, but OCHAMPUS has a specific policy permitting utilization review and quality assurance standards which include a peer review analysis and as such is in compliance with all Federal rules and regulations and even American Jurisprudence."

The Department of Defense has the responsibility of cost-sharing medical benefits that are determined by CHAMPUS and the fiscal intermediaries to be medically necessary. This is done through the definition of medical necessity contained in the CHAMPUS regulation as well as drawing upon the services of

medical reviewers, such as the medical review program established under the auspices of the American Psychiatric Association. Thus, the arguments of the sponsor are not applicable to a federal administrative program. Therefore, I find that the CHAMPUS determination of medical/psychological necessity by agency officials relying upon consultative opinions of medical reviewers was appropriate; CHAMPUS is not bound by determinations made by the attending physician.

Negligence In Review of Beneficiary's Claim

In addition, the beneficiary argued that the initial medical review by the American Psychiatric Association was performed in a negligent manner and the reviewers exhibited a bias against the beneficiary. A thorough review of the record leads me to conclude that such is not the case. The medical reviewers indicated that they reviewed the file, stated the time required to review the file, and did not exhibit any bias in the statements which they made concerning the questions posed to them for resolution. Further, this file was reviewed by two other psychiatrists; one review was under the auspices of the American Psychiatric Association and the other, an internal review, was by the Medical Director, OCHAMPUS, a psychiatrist. These individuals reached the same conclusion as two of the original three medical reviewers. I am persuaded that the conduct of the reviews by the medical reviewers was not performed in a negligent manner, was not arbitrary or capricious, and does not exhibit a bias against the beneficiary. Further, the appealing party has failed to demonstrate that the medical reviews were conducted in a negligent manner or that the medical reviews were biased against the beneficiary. The Hearing Officer found no negligence in the review of the appealing party's claim nor any violations of CHAMPUS regulations. I concur. The medical reviews conducted in this case provided the beneficiary with all the legal and administrative rights to which he is entitled under the Regulation and applicable law.

Discrimination Against The Beneficiary In Violation Of The Rehabilitation Act Of 1973, As Amended, 29 U.S.C. § 794 (1974)

Counsel for the appealing party contends that OCHAMPUS, by denying payment of the beneficiary's hospitalization in excess of 60 days, has discriminated against the beneficiary "because of the severity of his mental illness." It is counsel's argument that the medical reviewer's opinions were arbitrary and exhibited "utter disregard for the severity of [the beneficiary's] mental illness. Based on short concise recommendations from the peer reviewers, CHAMPUS intentionally denied CHAMPUS benefits to [the beneficiary] and the class of severely mentally ill who need inpatient hospitalization beyond sixty days. This discrimination is violation of §504 [Rehabilitation Act of 1973, as amended]."

It is Department of Defense policy "that no qualified handicapped person shall be subjected to discrimination on the basis of handicap under any program or activity that receives or

benefits from federal financial assistance disbursed by a DoD Component or under any federal program or activity that is conducted by a DoD Component." (DoD Directive 1020.1, Subject: "Nondiscrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense," dated March 31, 1982.) One of the DoD programs specifically identified by the DoD Directive as a federal financial assistance program subject to the Directive is CHAMPUS. Therefore, CHAMPUS beneficiaries cannot be denied benefits under the program on the basis of handicap.

The argument of counsel for the appealing party that the beneficiary has been discriminated against "because of the severity of his mental illness," however, is without merit. As discussed earlier in this decision, the opinions of the medical reviewers were not arbitrary, but were supported by the record. These reviewers opined that care beyond 60 days in an acute psychiatric hospital was not medically/psychologically necessary based upon little or no progress by the patient after the initial 60 days, absence of goals during the therapeutic process concerning education and evaluation, and the absence of documented signs and symptoms to justify extended hospital care. These opinions were not based on the appealing party's "handicap," but on the absence of medical information and documentation necessary to establish the medical/psychological necessity of the continued inpatient care in an acute psychiatric hospital.

As noted by the Hearing Officer: "In fact, CHAMPUS went far in excess of the requirement for review by engaging psychiatrists at the different levels of review to render opinions concerning the appropriateness of this claim. Adequate safeguards were taken to avoid any possible type of discrimination in the review of this claim." The denial of CHAMPUS cost-sharing, therefore, was not based on the beneficiary's "handicap," but upon the failure of the care in question to qualify for coverage under the CHAMPUS law and regulation.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the inpatient care at Barclay Hospital from November 6, 1980, to January 5, 1981, and services of the psychiatrist were medically necessary for the diagnosis and treatment of this beneficiary. However, it is the FINAL DECISION that the inpatient care at Barclay Hospital from January 6, 1981, to March 8, 1981, and psychiatric services be denied CHAMPUS coverage as the care is found to be not medically or psychologically necessary and above the appropriate level of care. The CHAMPUS claims for hospitalization and psychiatric services for this period and the beneficiary's appeal are denied. Issuance of this FINAL DECISION completes the administrative

appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

William Mayer, M.D.

84-36

RECOMMENDED DECISION

CIVILIAN HEALTH AND MEDICAL PROGRAMS FOR UNIFORMED SERVICES

(CHAMPUS)

IN THE APPEAL OF BENEFICIARY·

SPONSOR:

SPONSOR'S SOCIAL SECURITY NO.:

CASE NO.: 81 06302635

This case is before the undersigned Hearing Officer pursuant to a request for a Hearing by the sponsor through his representative, dated October 18, 1982. The office of Civilian Health and Medical Programs for Uniformed Services has granted this request for Hearing. This Hearing was conducted pursuant to Regulation DOD 6010.8-R Civilian Health and Medical Progams for Uniformed Services (CHAMPUS), Chapter X, Section F, Paragraph 4 and Section H, Paragraph 2B.

A Hearing was held before the undersigned on December 14, 1982, in the Federal Building, 536 South Clark Street, Chicago, Illinois pursuant to Notices sent by the undersigned on November 26, 1982, and November 30, 1982. The sponsor was personaly present at the Hearing and represented by Brooke R. Whitted, Esq. and Matthew D. Cohen, Esq. of CANEL, ARONSON & WHITTED. CHAMPUS was represented by Linda M. Bray, Esq. All evidence having been submitted at the time of the Hearing; the matter is now ready for a Recommended Decision.

Chapter IV.	A. 1.- Scope of Benefits
Chapter IV.	A. 10.-Utilization Review
Chapter IV.	C. 2. c.-Psychiatric Services
Chapter IV.	G. 1.-Not Medically Necessary
Chapter IV.	G. 3.-Innappropriate Level of Institutic Care
Chapter IV.	G. 32.-Minimal Brain Dysfunction
Chapter IV.	G. 44.- Educational/Training
Chapter VI.	A. 5.-Utilization Review: Quality Assur

Evidence Considered:

This Recommended Decision is based upon a thorough examination and consideration of the evidence contained in the exhibits which comprise the final Hearing file and includes the CHAMPUS Position Statement and the Sponsor's Position Statement, also the testimony adduced at the Hearing.

Summary of Evidence:

The record indicated that from November 6, 1980 through March 8, 1981, was a patient at the Barclay Hospital suffering from psychiatric problems which were diagnosed upon admission as, "atypical depression, identity disorder, over-anxious disorder of adolescence, conduct disorder and socialized unaggressive."

is the 17-year old son of the sponsor. The beneficiary's prior history indicates that he is of average intelligence but had long standing uncontrollable behavior problems which eventually required his hospitalization for his own protection. Exhibit 9 contains an adequate summary of prior activities.

His evaluations, course of treatment, testing, assessments and progress while at Barclay Hospital are thoroughly documented in the Hearing file. Specific reference is made to Exhibit Nos. 3, 4, 5, 6, and 9 of said file. These exhibits contain all of the medical documents pertaining to [redacted] case while he was a patient at the Barclay Hospital. On April 10, 1981, and August 13, 1981, [redacted] filed claims for the medical services rendered his son at said hospital for the above mentioned time period. Since the initial claim did not contain certain charges for psychiatric services, the sponsor filed an additional claim on said latter date. The initial 60 days of in-ptient hospital services were approved by Wisconsin Physician's Services, the local CHAMPUS intermediary, on May 18, 1981; the remaining services were denied as not the appropriate level of care required for the beneficiary's needs. The sponsor then proceeded through the appeal process by requesting an Informal Review followed by an automatic Reconsideration. In both instances, the initial decision of the CHAMPUS intermediary was upheld. After requesting and receiving a First Level Appeal Decision which indicated that the previous actions taken on the claim were proper under the provisions and requirements of the CHAMPUS Basic Program, the sponsor requested a Hearing.

Beside the medical documentation contained in the previously mentioned exhibits, the fiscal intermediary initiated both the first and second peer reviews. The first was conducted by three psychiatrists and submitted on April 21, 1981. (Exhibit 7) The second was also requested of three psychiatrists and submitted on August 26, 1981, September 4, and September 7, 1981. (Exhibit 12) Finally, CHAMPUS also submitted the beneficiary's case file to the American Psychiatric Association for a third peer review opinion. This review

was conducted on March 15, 1982. (Exhibit 19) At the Hearing, testimony was taken from two witnesses on behalf of the sponsor. They were Lawrence Heinrich, M.A., a registered psychologist at Barclay Hospital and also Marvin J. Schwartz, M.D., the president of Associates in Adolescent Psychiatry, S.C. Dr. Schwartz was an attending physician who had visited the beneficiary while at Barclay Hospital and since his primary attending physician, Marta Benegas, M.D., was no longer employed by A.A.T.S.C., Dr. Schwartz was requested to testify.

Both of the expert witnesses indicated the need for inpatient hospital services during the beneficiary's entire stay at the Barclay Hospital. Mr. Heinrich made specific reference to the beneficiary's uncontrollable behavior from January through March of 1981. He indicated that during that period of time, the beneficiary was not ready for any lesser type facility. He stated that was resistant to treatment, was sociopathic in his behavior, and uncontrollable. Dr. Swartz agreed with Mr. Heinrich's assessment of the situation. He also stated that discharge was not appropriate prior to March, 1981, as it took several months to get the beneficiary to a point where he could make such an adjustment to another placement. He also criticized the review by CHAMPUS indicating that he could not understand how a peer reviewer could form certain opinions in this area without seeing or interviewing the child.

The doctor was very firm in his convictions stating that he believed that either the child or someone else might have been dead if the beneficiary were released from the hospital at any earlier time. He continued further by stating that was a treatable child who suffered mental illness serious enough to be

considered a handicap, that he had specific learning disabilities which were a manifestation of his mental illness and that at the Barclay Hospital, the treatment received, allowed him to overcome these problems through various multiple services. Both witnessess stated that the initial length of stay was indicated at between 60 and 75 days based on the hospital's charting requirements demanding the use of minimal lengths of stay, but because of lack of improvement, and a change of goal from homeliving to a Residential Treatment Center, the length of stay was increased. Both witnesses also concurred that probably should have been kept at the hospital longer but outside family pressures prevailed, and he was discharged to a Residential Treatment Center where after initially running away he did in fact make a substantial recovery.

The sponsor also testified concerning his son's prior behavior and improvement through the medical services rendered at Barclay Hospital. He stated after the initial 60 days at Barclay Hospital, was still "out of control", and he, in fact, improved between that time and his eventual discharge. He also stated that upon discharge, was a changed man and that he believed very strongly that the additional two month stay saved his son's life.

The psychiatrists who conducted the peer reviews on behalf of the fiscal intermediary and CHAMPUS, basically concluded with one exception that the beneficiary's hospital stay was far too long based upon his symptoms and diagnosis. The majority of the reviewers disagree with the hospital's diagnosis of the beneficiary. Specific reference is made to the review by James Egan, M.D., a medical expert in child psychology; he states that the proper diagnosis is "under-

socialized conduct disorder-aggressive type," that after the initial 60 days of hospitalization, the beneficiary should have been placed in a Residential Treatment Center.

Evaluation of the Evidence:

All of the experts on either side of the issues involving this case are firm in their convictions as to the proper mode of treatment for the beneficiary. Usually, in considering the strength and weight of the evidence presented, that of the attending physician is usually given preference since that person is dealing with the beneficiary on a weekly, if not daily basis. In this situation, it should be noted that the records from the Barclay Hospital were well kept and thorough, therefore, any outside reviewer who is an expert in his field, namely psychiatry, could formulate a fair and impartial opinion as to the appropriate level of care being rendered a beneficiary. The attending physicians at Barclay Hospital who made the daily or weekly evaluations are faced, however, with certain pressures from the institution and the patient's family, nevertheless, the hospital record must justify each and every decision so as to provide the reviewer with the proper information to justify the treatment and length of stay.

Rationale:

This is a complex case with multiple issues to be determined CHAMPUS regulations in Chapter IV section A. 10. state that prior to the extension of any CHAMPUS benefits under the basic program, claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for the quality of care and appropriate utilization. The Director of OCHAMPUS is ultimately responsible for setting forth the standard norms and criteria

as necessary to assure compliance with this review. It specifically states;

> Utilization Review and Quality Assurance Standard, norms and criteria shall include, but not be limited to, need for in-patient admission, length of in-patient stay, level of care, appropriateness of treatment, level of institutional care required, etc., implementing instructions, procedures and guidelines may provide for retrospective, concurrent, and prospective review, requiring both in-house and external review capabilities on the part of both CHAMPUS Contractors and OCHAMPUS.

The above cited guideline is also reiterated in Chapter XI, Section A. 5. which pertains to providers. These rules clearly establish a policy whereby OCHAMPUS can determine the need for medical services as requested under its basic program. The sponsor has argued that their exists case law specifically a Cook County Circuit Court Case which is made part of the Hearing file (Exhibit 22) indicating that only the attending physician can made determinations regarding medical necessity. It should be noted, however, that Section D of Chapter I of the CHAMPUS regulation, specifically states that CHAMPUS is not subject to those state regulatory bodies or agencies which control the insurance business generally. True, that the weight of authority usually suggests that discretion rests with attending physicians, but OCHAMPUS has a specific policy permitting utilization review and quality assurance standards which include a peer review analysis and as such is in compliance with all Federal rules and regulations and even American Jurisprudence.

The sponsor also contends that CHAMPUS was negligent in its review and violated CHAMPUS regulations by failing to apply appropriate standards. In reviewing the request for peer review by the fiscal intermediary and OCHAMPUS, it appears that proper guidelines were applied as established by CHAMPUS in its Manual for In-patient and Out-patient Psychiatric Claims Review. All of

the reviewers were specifically requested to make determinations concerning the issue which involved the appropriateness of the level of care, the length of stay and for medically necessary treatment. The proper review standards are set forth in the previously mentioned rules and regulations and were fully complied with. There exists no evidence that any more stringent review standards were applied to this claim. It is true that under Section A. 1. of Chapter IV, CHAMPUS will make allowances for medically necessary services and supplies required in the diagnosis and treatment of an illness or injury; however, naturally subject to utilization review and quality assurance standards are necessary to properly manage the program.

The sponsor also contends that OCHAMPUS has intentionally discriminated against the beneficiary because of his severe handicapped condition in violation of the Rehabilitation Act priviously cited. As a Federal agency, naturally CHAMPUS is bound to follow proper rules and regulations in the determination of any claims so as not to violate a handicapped's or any other individual's rights under the Program. In fact, CHAMPUS does provide a program for the handicapped as indicated in Chapter V of the Regulation. There is no evidence that the procedure followed by OCHAMPUS in the review of this claim was in violation of the Rehabilitation Act. In fact, CHAMPUS went far in excess of the requirement for review by engaging psychiatrists at the different levels of review to render opinions concerning the appropriateness of this claim. Adequate safeguards were taken to avoid any possible type of discrimination in the review of this claim.

At the Hearing, the CHAMPUS representative raised an issue concerning the exlusion of this claim under the CHAMPUS

Basic Program based upon testimony indicating that the beneficiary suffered from a learning disorder and required special educational services. Such services are listed under Sections G 32 and 44 of Chapter IV. The testimony form both expert witnesses indicated that the beneficiary did have a learning disability and received special type education; however, as Dr. Schwartz indicated, this learning disability was a manifestation of his mental illness and the special education he received was in conjuction with the over-all treatment program consisting of a multi-services approach which was provided at Barclay Hospital.

The main issue in this case deals with the appropriate level of care; that is in order for a claim to be approved by CHAMPUS under its Basic Program the services provided must be medically necessary. Section B.104 of Chapter II of the regulation states as follows:

> "Medically Necessary" means the level of services and supplies, (that is, frequency, expense and kind) adequate for the diagnosis and treatment of illness or injuries (including maternity care). Medically necessary includes concept of appropriate medical care.

The term appropriate medical care is defined in various ways but specifically with regard to this matter, the definition is found in Section B. 14. C. of said Chapter II which states as follows:

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

Both of these terms must be taken in conjuction with each other so as to determine whether a beneficiary is receiving the appropriate level of care required for medically necessary treatment.

The differences of opinion among the experts relating to the beneficiary's level of care appear to be sharply divided;

however, the final determination of placement was similar if not the same by all experts. All evaluations finally determined that should be placed in a Residential Treatment Center as defined by Section B. 155 of Chapter 2. Such a facility provides for specifically round-the-clock, long-term psychiatry treatment of emotionally disturbed children who have sufficient intellectual potential for responding to active psychiatric treatment, for whom out-patient treatment is not appropriate, and for whom in-patient treatment is determined to be the treatment of choice. Eventually, was placed in such a facility and did function as a normal young man.

All of the experts finally concluded that such a facility was best for the beneficiary. A question arises as to the difference of opinion among the experts as to the time when such a facility was appropriate. In reviewing the hospital record, careful consideration is given to Exhibit No. 9, page 6 "Social Assessment" wherein the recommendation by the clinical services department on November 17, 1980, only 11 days after the beneficiary's admission to the hospital, was that alternatives to his returning home may need to be explored after an assessment of family therapy. Also on page 10 of said exhibit, entitled "Psychological Evaluation" wherein on November 19, 1980, only 13 days after his admission, the Regestered Psychologist and School Psychologist indicated that it would appear that it may be necessary that placement in a long-term structured setting away from the family interactional patterns may be necessary for the application of the patient's intellectual potential in obtainment of reasonable academic goals.

It is also noted that not until January 9, 1981, in the Weekly Psychologist Summary Report is there a mention of probable placement in a Residential Treatment Center. (Exhibit 5) Although on December 30, 1980, in the discharge planning portion of the Summary, the Attending Psychiatrist was awaiting or expecting changes to occur at home. (Exhibit 6) Evidentally such changes still created a problem, for on January 10, 1981, another Summary indicates that residential treatment is being sought. (Exhibit 6)

At the time of the beneficiary's admission, the psychiatric examination performed on November 7, 1980, concluded that hospitalization was the least restrictive alternative treatment at that time. (Exhibit 9 page 16) Testimony at the Hearing from the expert witnesses concluded initially that unification with the family was the ultimate goal but this was changed some time during the month of January. It would appear from the records that problems with such an initial discharge plan, that is unification with the family, were apparant even within 11 - 13 days after the beneficiary's admission. Why it took so long to formulate a new discharge plan when the record indicates the problems with the beneficiary during this time from November, 1982, to January, 1981, is questionable. Whether there were problems with the parents' intervention which is very apparant even up to his eventual discharge in March, 1981, or whether there was an adequate diagnosis of the problem are unknown, but the majority of the experts who reviewed the file and hospital record evidently discovered these problems and recommended only a 60 day hospital stay.

The physicians at Barclay Hospital are very competent and steadfast in their determinations; however, the rules and

regulations of the CHAMPUS program require the necessity of adequate documentation and proof of the need for medical services. The sponsor has failed to meet the burden of proof necessary to adequately establish the approprate level of care as required in medically necessary treatment of the beneficiary in excess of 60 days.

Findings:

1. is a 17-year old beneficiary who received total in-patient hospital care and adolescent psychiatric & psychological services at the Barclay Hospital from November 6, 1980, through March 8, 1981.

2. The beneficiary was in need of such medical services for the initial 60 days of his hospital stay.

3. The medical services received by at the Barclay Hospital subsequent to January 6, 1981, was not the appropriate level of care required for medically necessary treatment and as such not a covered benefit under the CHAMPUS Basic Program.

4. A medical necessity determination made by OCHAMPUS based on opinions from reviewing physicians through the American Psychiatric Association Peer Review is appropriate pursuant to CHAMPUS regulations.

5. CHAMPUS was not negligent in its review of the beneficiary's claim and did not violate CHAMPUS regulations.

6. CHAMPUS applied the appropriate review standards in conducting its review of this Hearing and denying care beyond the initial 60 days.

7. CHAMPUS did not descriminate against the beneficiary because of his severe handicapping condition in violation of the Rehabilitation Act.

8. does not suffer from a learning disorder for which he received special education to make him excluded from CHAMPUS Basic Program.

Recommended Decision:

It is the recommendation of the undersigned Hearing Officer that the OCHAMPUS decision of August 28, 1982, denying in-patient care beyond the initial 60 days as the level of care was found to be above the appropriate level required to provide medically necessary treatment for the patient be upheld and this appeal be denied.

VALENTINO D. LOMBARDI
Hearing Officer
127 Dorrance Street
Providence, RI 02903

Date: February 17, 1983