ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

27 NOV 1984

BEFORE THE OFFICE, ASSISTANT
SECRETARY OF DEFENSE (HEALTH AFFAIRS)
UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File
	)	FINAL DECISION 84-37
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-37 pursuant to 10 U.S.C. 1071-1092, and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary, a retired officer of the United States Army. The appeal involves the denial of CHAMPUS cost-sharing for 17 outpatient psychotherapy sessions of the beneficiary for the period of October 21, 1982, through May 21, 1983. The amount in dispute is $1,050.00.

The hearing file of record, the tape of oral testimony and the argument presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that CHAMPUS cost-share two psychotherapy sessions per week provided the beneficiary from October 21, 1982, through May 21, 1983, and deny the third session per week during this period because the extra session was not medically/psychologically necessary nor appropriate care.

The Director, OCHAMPUS, concurs in the Recommended Decision and recommends the adoption of the Recommended Decision as the FINAL DECISION. The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer 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 allow CHAMPUS cost-sharing of the appealing party's claims for two weekly psychotherapy sessions from October 21, 1982, through May 21, 1983, and to deny CHAMPUS cost-sharing of the third weekly psychotherapy session provided the beneficiary during the same period of time. This determination is based on findings that: (1) the two sessions of weekly psychotherapy were medically/psychologically necessary and appropriate care in the treatment of the beneficiary's illness, and (2) the record fails to disclose any evidence that the beneficiary's condition was so severe and complex requiring a

frequency of therapy above the regulatory norm (i.e., two outpatient psychotherapy sessions per week).

FACTUAL BACKGROUND

The beneficiary, a retired officer in the United States Army, became very depressed and sought assistance from the Veterans Administration Hospital in La Jolla, California. After examination by a staff psychiatrist, the sponsor was directed to seek immediate psychiatric treatment. On October 21, 1982, he became a patient of Dr. Suskind and began outpatient psychotherapy. The treating psychiatrist recommended that the sponsor receive therapy (psychoanalysis) five times a week or, in the alternative, that the sponsor have three therapy sessions a week for a trial period to see if that frequency of sessions was adequate.

The beneficiary began seeing the psychiatrist three times a week until the treatment was terminated on May 21, 1983. During the same period of time, the beneficiary also was prescribed medication which was cost-shared by CHAMPUS and is not an issue in this appeal. The CHAMPUS Fiscal Intermediary notified the beneficiary in March 1983 that three psychotherapy sessions per week would not be allowed because it exceeded the regulatory norm under the CHAMPUS Program.

The Hearing Officer's Recommended Decision describes in detail the beneficiary's medical condition, the events leading to his treatment, and the reasons for the denial of CHAMPUS cost-sharing of the third weekly session of psychotherapy. The Hearing Officer has provided a detailed summary of the factual background, including the appeals that were made, the previous appeals denials, the medical opinion of the medical reviewers conducted at the direction of the fiscal intermediary, and the medical opinions rendered by the OCHAMPUS Medical Director and Assistant Medical Director. Because the Hearing Officer adequately discussed the factual record, it would be unduly repetitive to summarize the record, and the Hearing Officer's Recommended Decision is accepted in full and incorporated in this FINAL DECISION.

The Hearing was held on May 24, 1984, at San Diego, California, before OCHAMPUS Hearing Officer, Hannah M. Warren. Present at the Hearing were the sponsor and a representative from OCHAMPUS. The Hearing Officer has issued her Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are whether the third weekly session of psychotheraphy provided to the beneficiary for the period of October 21, 1982, through May 21, 1983, was medically/psychologically necessary and appropriate care, and whether the beneficiary's condition was so severe and complex as

to require a frequency of therapy above the regulatory norm established in the CHAMPUS Regulation.

Medical Necessity/Appropriate Level of Care

The Department of Defense Appropriation Act, 1983, Public Law 97-377, 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, [or] clinical psychologist. . . ." This restriction has consistently appeared in each subsequent Department of Defense Appropriation Act.

The CHAMPUS regulation, DoD 6010.8-R, is consistent with the above statutory limitation by defining the scope of 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. . . ."

The CHAMPUS regulation, DoD 6010.8-R, chapter II, B.104., defines "Medically Necessary" 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 Regulation also defines "Appropriate Medical Care" in chapter II, B.14., in part as:

> "a. 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."

Finally, the CHAMPUS regulation (DoD 6010.8-R, chapter IV, paragraph C.3.i.) generally limits coverage of outpatient psychotherapy to a maximum of two sessions per week. Before CHAMPUS cost-sharing can be authorized for more than two sessions per week, peer review will be conducted to establish the medical necessity and appropriateness of the extra sessions.

The Hearing Officer in her Recommended Decision correctly referenced the applicable law, regulations, and a prior

precedential FINAL DECISION in this area (OASD(HA) Case File 83-01, April 8, 1983). After reviewing the facts in this case in light of the applicable authority, the Hearing Officer found that:

> "In view of the lack of documentation I can only conclude, as did two of the APA peer reviewers and both the Medical Director and the Assistant Medical Director of OCHAMPUS, that the [beneficiary] could have been managed with medication and two times a week psychotherapy and that he was not an exception to the general regulatory requirement.
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> "I have concluded that the appealing party has failed to meet [his burden of evidence] as the regulation regarding frequency of outpatient psychiatric care is specific and there is no evidence that has been presented to show the patient's condition was so severe and complex as to require a frequency of therapy above the regulatory norm, even though it may well have been the treatment of choice between the patient and his physician.
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> ". . . the outpatient psychotherapy rendered to the beneficiary from October 21, 1982, through May 21, 1983, be allowed at a frequency of two psychotherapy visits per week and that the third visit per week during this period of time was above the appropriate level of care and thus not medically necessary. . ."

The Hearing Officer recommended that, because the appealing party failed to demonstrate that his condition was so severe and complex as to justify psychotherapy beyond two sessions per week, the third session of psychotherapy per week be denied CHAMPUS cost-sharing.

I concur in the Hearing Officer's Findings and Recommendations. I hereby adopt in full the Hearing Officer's Recommended Decision, including the Findings and Recommendations, as the FINAL DECISION in this appeal.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to allow CHAMPUS cost-sharing of two psychotherapy sessions per week for the period of October 21,

1982, through May 21, 1983, and deny the third session of psychotherapy per week during this period of time as not medically/psychologically necessary nor appropriate care. The appealing party has failed to demonstrate that his condition was so severe or complex as to establish the medical/psychological necessity of an additional session of psychotherapy per week. Although the CHAMPUS Fiscal Intermediary initially paid for some of the extra sessions during the initial stages of treatment, the appealing party has reimbursed CHAMPUS for those overpayments for the third weekly session. Consequently, recoupment action is not required in this case. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

for William Mayer, M.D.

Rec Del
84-37

RECOMMENDED HEARING DECISION

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

Beneficiary: , Colonel USA (Ret.)

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. 1079-1089 and DoD 6010.8-R, Chapter X. The appealing party is the beneficiary, a retired colonel in the U. S. Army. The appeal involves the denial of CHAMPUS cost-sharing for 17 outpatient psychotherapy sessions from October 21, 1982 through May 21, 1983. The amount in dispute is approximately $1,050.00, which is the actual amount which would be paid by CHAMPUS if the sessions were to be cost-shared.

The hearing file of record has been reviewed along with the testimony given by at the hearing. It is the OCHAMPUS position that the Formal Review Decision issued December 23, 1983 denying CHAMPUS cost-sharing for more than two outpatient psychotherapy sessions per week be upheld on the basis that under the CHAMPUS Regulation care beyond that frequency was not shown to be medically necessary or appropriate level of care nor was there documentation of crisis intervention that would necessitate the third session per week.

The Hearing Officer, after due consideration of the appeal record, concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing beyond two outpatient psychotherapy sessions per week. The recommended decision of the Hearing Officer is therefore to deny cost-sharing for the third outpatient psychotherapy session per week the beneficiary received during the period of treatment from October 21, 1982 through May 21, 1983.

FACTUAL BACKGROUND

The beneficiary was fifty-two years old when he became very depressed and went to the Veterans Administration Hospital in LaJolla, California. He was examined by a staff psychiatrist at that hospital on an outpatient basis and was told he should seek immediate psychiatric treatment. He was given the names of several psychiatrists and the one most highly recommended was Dr. Davis A. Suskind. On October 21, 1982 the beneficiary became a patient of Dr. Suskind and was told he needed outpatient psychotherapy. It was recommended that he come for therapy (psychoanalysis) five times a week or, in the alternative, that he come three times a week for a trial period to see if that was adequate and if it was not successful they would increase the frequency to five times a week. He was seen three times a week during the entire period until treatment was terminated on May 21, 1983. He also received medication during the entire period which was cost-shared by CHAMPUS and is not at issue in this hearing.

Claims were submitted for these psychotherapy sessions and the three sessions per week were reimbursed by the fiscal intermediary for the months of October and November. When the claim for services provided in December, 1982 was processed the issue was raised that CHAMPUS benefits would only be extended for two sessions per week. The beneficiary did not receive notice that three sessions per week would not be allowed until March, 1983. Both the beneficiary and the treating physician wrote letters to OCHAMPUS explaining the treatment which was being received and the beneficiary testified at the hearing they both assumed this would explain the necessity for three times a week therapy and all submitted claims would be paid. It was not until after the beneficiary had terminated treatment in May, 1983 that he was advised only two sessions a week would be allowed. All benefits paid by the fiscal intermediary for the third session per week have been refunded by the beneficiary.

The fiscal intermediary conducted an informal review and notified the beneficiary by letter dated April 21, 1983 of the cost-sharing denial for the third psychotherapy session per week from December 2 through December 23 and requested additional information (Exhibit 7). The hearing file shows Dr. Suskind had submitted a written narrative summary on February 14, 1983 (Exhibit 8). He described the beneficiary's illness as "severe depression with suicidal ideation" in the fall of 1982, following his divorce finalization and under the strain of uncertainty of his heterosexual relationships. He had identity problems and confusion about his place in life." Elavil, 150 miligrams daily was started and the doctor said this patient achieved a good response regarding his acute depression. "He became much more functional in work but his self-esteem continued to be highly confused, narcissistically dependent upon pleasing authorities by his perfectionistic activities and barely aware of his chronic hostility and self-isolation for feeling betrayed by these same authority figures." At the end of the problem description the doctor states: "At present there is no defective reality testing or suicidal ideation. He remains impaired in his ability to fully utilize his talents in his profession, being burdened by conflicts mentioned above regarding perfectionisn versus withdrawal from authority and sexuality." As to the outpatient treatment plan, the doctor writes he has been able to form a "solid therapeutic alliance and has already modified some of his problematic behaviors. A good response to the beginning phase of treatment has been achieved. Long-term treatment is necessary in view of the characterologic nature of his symptoms and inhibitions." He reports the patient will remain on Elavil, 150 miligrams daily, until May 1983 at which time the medication will be gradually withdrawn. (Exhibit 8, page 2)

The physician wrote to the fiscal intermediary reiterating much of what I have quoted above and referred to the detailed diagnostic narrative summary dated February 14, 1983 (Exhibit 8 above). He concludes: "I believe his treatment optimally requires his being seen in intensive psychotherapy at a minimum of three times a week." (Exhibit 6, page 1). The treating physician again wrote on April 30, 1983, at that time giving his diagnosis as (1) acute depression with suicidal features, and (2) compulsive characterologic features. He again refers the fiscal intermediary to his February 14, 1983 summary. The new information in this letter is as follows: "Specifically regarding the three questions you posed in your letter dated April 21, 1983 to Dr. .. ; the specific goals for his treatment had been twofold. First, stabilization and treatment of his acute and serious depressive disorder. A combination of intensive psychotherapy and anti-depressive medication have resulted in the achievement of this goal. Second, his characterological (personality) disorder

reflects chronic symptoms of compulsive and conflictional relationships which are described in the accompanying "Narrative Summary". These are chronic symptoms imbedded in a rigid character structure which broke down last year. Without alteration of this rigidity, he continues to experience impaired relationships with significant people and vulnerability to recurring depression. This chronic 'behavioral dysfunction' has, and will continue to require intensive treatment. Currently we are titrating the patient off his Elavil, and will be better able to assess the required intensive further therapy when he has stabilized off of medication. I emphasize that his predominant problem is of a characterological nature which should be taken into consideration in your review." (Exhibit 8, page 1)

The fiscal intermediary wrote to the physician on August 17, 1983 (Exhibit 12) and requested an initial psychological evaluation, initial treatment plan and goals with updates and progress notes. The doctor responded by again sending copies of the above-quoted letters along with another narrative summary dated July 17, 1983 and a summary of evaluations, November 11, 1982 (Exhibit 13). In this summary he referred them to reports of February 14 and April 30 for discussions of treatment and goals and stated, "This man's severe depression and suicidal ideation resolved with intensive psychotherapy and tricyclic antidepressant medication. We have been making inroads regarding modification of his obsessional and significant narcissistic problems, which clearly predisposed him to his depressive decompensation." He then reported that the payment issue interfered with progress and resulted in the termination of treatment although the patient was in the midst of key life changes and additional treatment would have been helpful: "On the other hand, he can be considered no longer depressed." In this letter of August 27, 1983 (Exhibit 13, page 1), the physician reiterates some of the depressive problems and the medication the patient was receiving and states: "Over the months we were able to examine [redacted] problems in his workplace, and in his personal life, as well as the determinants in the past that made it difficult for him to be happy with his life. An important aspect of his therapy was our focusing in or the quality of the interaction between [redacted] and myself. [redacted] was able to utilize this type of approach quite successfully and was able to begin to be more self-observant and less rigid with himself and others." He again reiterates that the CHAMPUS denial of payment complicated his ability to deal with identity issues.

After receiving the February narrative summary and the April correspondence from the treating physician, the fiscal intermediary sent the claim to the American Psychiatric Association for peer review, which was conducted in May 1983 (Exhibit 3). All three reviewers found the therapy for treatment of the beneficiary's illness was appropriate. One reviewer stated, "It appears that type of therapy is an interpretative-supportive type, though this is not specifically mentioned. Medication is appropriate and so is the type of psychotherapy if that is what is being used with him." His opinion was, "The data submitted does not make it clear to me why two visits plus combined use of medication is not sufficient. I would recommend two visits weekly unless a stronger case is made for three times weekly than has been submitted." (Exhibit 3, page 3). The second reviewer found the therapy to be skillful and appropriate, but felt that the frequency should be reduced to two sessions per week stating: "There simply isn't an adequate justification to keep it at three times weekly." (Exhibit 3, page 2). The third reviewer concluded as follows: "Marked improvement is reported both by therapist and patient. The narrative summary, although brief, gives the impression that competent work is

being done. The therapist states that the characterologic problems require this frequency of visits. I am inclined to agree that there is a better chance of altering life-long compulsive patterns with a frequency of three visits per week than with lesser frequency. I agree that modification of the character structure is essential if future depressive episodes are to be avoided. The total number of sessions may be less with more intensive therapy. For these reasons I think that the type of therapy and the level of intensity are appropriate." (Exhibit 3, page 1).

After being notified of the fiscal intermediary's Reconsideration Decision, wrote to OCHAMPUS (Exhibit 10) and this letter was treated as a formal review request and additional information was requested (Exhibit 13). The physician submitted the additional information described above (letters dated April 4th and 30th, Summary dated July 17, 1983, and Summary of Evaluation, November 11, 1982), in response to this request (Exhibit 13). A review of the claim was then conducted by the OCHAMPUS Medical Director and the assistant Medical Director, both of whom are psychiatrists (Exhibit 14), on September 12, 1983. The report is as follows: "Dr. Kolb and Dr. Rodriquez both concurred with two of the three peer reviewers in the file in that only two psychotherapy sessions were medically necessary per week. The medical records do not justify more than two sessions per week in their opinion. They indicate therapy is supportive and two sessions per week is the maximum required for that type of care." (Exhibit 14). An OCHAMPUS Formal Review Decision was issued December 23, 1983. This decision upheld the previous denial of cost-sharing for the third session per week during the entire period of care and instructed that recoupment action be initiated as regards the third session per week which had been allowed in November and December 1982.

Dr. Kolb, the OCHAMPUS Assistant Medical Director, was asked to expand his previous medical opinion for the hearing file and also to address the issue raised by as to whether the psychotherapy was crisis intervention (Exhibit 18). Generally Dr. Kolb felt the information which was available was very limited, which made it very difficult to make a decision. He stated that two sessions a week would ordinarily be enough and even if a higher frequency was appropriate at the outset of treatment, lack of progress notes made it impossible to make a determination. He also found there was no evidence of a crisis in the record (save possibly the original divorce) and it was unlikely that any crisis would last six months.

The beneficiary filed a timely request for hearing and a hearing was held May 24, 1984 before CHAMPUS Hearing Officer Hanna M. Warren and the beneficiary at the Federal Building, San Diego, California. Linda M. Rediger attended the hearing representing OCHAMPUS.

ISSUES AND FINDINGS OF FACT

The primary issue in dispute is whether the care provided the beneficiary was at the appropriate level of care and medically necessary at the frequency of three outpatient psychotherapy sessions per seven day period during the period October 21, 1982 through May 21, 1983. Secondary issues that will be addressed include the issues of delay in notification and burden of evidence.

Chapter II of the CHAMPUS Regulation DoD 6010.8-R provides basic program benefits and in paragraph 1 describes the scope of benefits as "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 or treatment of illness or injury..." There is an overriding requirement in the Regulation and in the Appropriations Act that cost-shared services must be medically necessary which is defined in Chapter II of the Regulation as "the level of services, supplies (i.e., frequency, extent and kinds) adequate for the diagnosis and treatment of illness and injury. Medically necessary includes concept of appropriate medical care."

Paragraph 14 of Chapter II describes appropriate medical care as medical services which "are in keeping with the generally acceptable norm for medical practice in the United States", provided by a licensed or certified professional, and where "the medical environment in which the medical services are performed is at the level adequate to provide the required medical care."

Along with outlining the scope of basic benefits, Chapter IV also provides there must be utilization review and quality assurance. "Prior to the extension of any CHAMPUS benefits under the Basic Benefit Program as outlined in this Chapter IV, claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for quality of care and appropriate utilization.....Such utilization and quality assurance standards, norms and criteria shall include, but not be limited to, need for inpatient admission, length of inpatient stay, level of care, appropriateness of treatment, level of institutional care required, etc." Chapter IV.A.10.

Chapter IV extends CHAMPUS benefits for professional services and states "Benefits may be extended for those covered services described in Section C of Chapter IV which are provided in accordance with good medical practice and established standards of quality by physicians...Such benefits are subject to any and all applicable definitions, conditions, exceptions, limitations and/or exclusions as may be otherwise set forth in this or other chapters of this Regulation." There follows provisions for certain specific professional benefits such as surgery, anesthesia, physical therapy, maternity care, etc., and one of these specific provisions is for psychiatric procedures. It provides in pertinent part as follows:

"Chapter IV.C.3.i. Psychiatric Procedures.

"(3) Review and Evaluation. Outpatient. All outpatient psychotherapy are subject to review and evaluation at eight session visit intervals. Such review and evaluation is automatic in every case at the initial eight session visit interval and the 24 session visit interval (assuming benefits are approved up to 24 sessions). More frequent review and evaluation may be required if indicated by the case. In any case where outpatient psychotherapy continues to be payable up to 60 outpatient psychotherapy sessions, it must be referred to peer review before any additional benefits are payable. In addition outpatient psychotherapy is generally limited to a maximum of two sessions per week. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, peer review is required."

At the hearing the beneficiary recognized that the normal frequency for outpatient psychotherapy visits which qualified for CHAMPUS benefits was two per week, but it was his position that he was the exception which was implied in the statement in Chapter IV.C.3.i.(3). He testified he was suicidal at the time he started treatment with Dr. Suskind, and there was no doubt in his mind that if he had not received help at that point in his life he would have

committed suicide in that he had planned in detail how he would do it. He said the sessions were very unpleasant and difficult and not the sort of thing one would undertake just for a visit, and that the medication he took had rather serious side effects (lethargy, impotence, physican weakness). He vigorously maintained he did what a responsible patient would do. He put his trust in a well-recognized and well-recommended psychiatrist and followed that physician's advice regarding his treatment. This testimony raises one issue I would like to discuss at the beginning of my findings because I feel it is very important in view of the testimony which the patient gave at the hearing. As Hearing Officer, I am not deciding that the beneficiary should not have been seen three times a week or that he should have disagreed with the recommendation of his treating physician. I whole-heartedly agree with the beneficiary that as patients we do what our doctors recommend if we have confidence in them. What treatment a patient receives is always a decision between the doctor and the patient and it is clear from the record that the treating physician in this case felt it was necessary for the patient to be seen at least of three times a week. In fact there was some discussion at the beginning of treatment that the patient be seen five times a week in psychoanalysis. I am not deciding whether that was a correct recommendation or not. I am only deciding whether payment will be made for more than two outpatient psychotherapy visits a week based upon the clear guidelines for CHAMPUS coverage. At one point in the hearing the beneficiary described the situation as his treating physician and the VA physician on one side and the CHAMPUS and peer review doctors on the other. I do not believe this is an accurate charaterization of the issue in this hearing. All of the physicians that have been involved in this claim,including those from OCHAMPUS and the APA peer review project, agreed that the patient needed psychiatric treatment. The only question is whether there were circumstances in this case that required the patient to be seen at a greater frequency than the generally provided CHAMPUS benefits. At another point the beneficiary implied that CHAMPUS was implying his doctor was not conducting himself as a good psychiatrist would and that he had misdiagnosed the treatment plan. Again, I cannot let this go by without emphasizing that I do not believe that is the OCHAMPUS position, and it is certainly not what I am holding in this hearing decision. The issue in this decision is that we have a specific CHAMPUS Regulation which states that coverage will be provided for outpatient psychotherapy but it is generally limited to two sessions per week and before benefits can be extended for more than two sessions a week, peer review is necessary. Psychiatric claims especially, because of the nature of the services provided and the long-term treatment which is usually involved are uniquely subject to peer review determinations regarding coverage. This requirement is found several places in the Regulation and as to the services regarding this claim, is specific. Any time you utilize peer review to make recommendations regarding coverage, there is a need for adequate documentation and I believe this is partially the problem in this case.

The CHAMPUS peer review project developed in relation to the requirements contained in the Regulation. Because of the frequent length of treatment and diversity of treatment methods, it is difficult for lay people, including Hearing Officers and fiscal intermediaries, to supply the standards or criteria by which medical/psychiatric necessity is determined. The American Psychiatric Association and American Psychological Association peer review projects were undertaken to assist in this determination. In the mental health field there are many different therapeutic approaches as shown by the facts in this hearing, and this varied approach to mental health treatment makes reliance on peer review more appropriate and important. Because as Hearing Officer I am

bound by the CHAMPUS Regulation regarding the need for an appropriate level of care in order for the care to be medically necessary within the CHAMPUS governing provisions, and also the specific regulation regarding the general limitation of two times a week outpatient psychotherapy. For this reason I have discussed in detail above the peer review opinions and must give them considerable weight in making my decision.

At the hearing the beneficiary pointed out that the peer reviewers had no detailed knowledge of him, they had not interviewed him nor had they interviewed the doctor who treated him. An examination of this position shows compliance would be difficult if not impossible. Because of the nature of medical treatment, by the time the claim is submitted and the peer reviewers are brought into the picture the patient's situation may be very different and a decision as to what was happening at the beginning of treatment would be difficult. For this reason, all peer review relies of necessity upon documentation by the treating or attending physician contemporaneously with the care being rendered. As Hearing Officer, I understand that none of the doctors, save for the treating physician, actually saw the patient. This is something that I should and do consider in making my decision. The problem in this hearing is that I have only one piece of information which is contemporaneous with the care which was given, and that is the treatment report of February, 1982. All of the other material in the file is written by the treating physician as an after the fact response to CHAMPUS denial of benefits. I must consider this, too, in making my decision. All but one of the six psychiatrists who examined the documentation which was available to them felt this patient could have been treated adequately with medication and two times a week psychotherapy. There is no documentation, nor testimony at the hearing, to support the beneficiary's position that he is an exception to the general Regulatory provision. Although the beneficiary pointed out that the peer reviewers were split and ambiguous and admitted they did not know enough about the case to make an opinion as he read their reviews, this cannot be the basis for my making an exception to the general provisions for coverage. A discussion was held at the hearing regarding the disclosure of sensitive information and the treating physician's concern about protecting the patient's privacy. I believe that doctors, including psychiatrists, are very aware of this need and rightly so, but progress notes can be maintained over a seven month period which provide some documentation for the care which was given and still provide a measure of privacy to the patient. Dr. Kolb's discussion of the case in Exhibit 18 is very pertinent to my concern as Hearing Officer. Although he found the suicidal ideation was not documented in an initial psychological workup or physician notes, the testimony at the hearing has convinced me the patient was suicidal and clearly needed psychiatric intervention. I agree, though, with Dr. Kolb that even if at the beginning a more intensive outpatient treatment was needed, there is no documentation as to what would be an appropriate time to make a determination that the regulatory norm of two sessions per week would have been appropriate. The beneficiary clearly saw himself as very ill at the time he started treatment and it is possible if the records had been more extensive, more frequent therapy at the beginning could have been found to be appropriate and medically necessary. It is clear by February 14, 1983 the doctor felt the beneficiary had achieved a good response to his depression and was no longer suicidal, but the record does not show when this response occurred clinically. I realize that it did not happen overnight, but at some point in the treatment, the physician must have noted a decrease in concern regarding the diagnosis of "severe depression with suicidal ideation." We cannot identify when that occurred from the record. In view of this lack of

documentation I can only conclude, as did two of the APA peer reviewers and both the medical director and assistant medical director of OCHAMPUS, that the patient could have been managed with medication and two times a week psychotherapy and that he was not an exception to the general regulatory requirement.

The beneficiary by letter dated January 24th, 1984 (Exhibit 16), stated that both the examination at the VA Hospital and at the onset of his treatment there was a crisis situation which "warranted intensive and extraordinary treatment beyond that which is normally required or administered." Again, there is nothing in the record to indicate this nor did the treating physician describe the treatment which was rendered as crisis intervention. I agree with Dr. Kolb that if there was crisis intervention it was not documented and it is unlikely that a crisis would have lasted for the almost seven month period which the patient was seen. I understand the patient stating that there was a crisis at the time he went into treatment because of his suicidal intention but it is not adequately documented that this required three times a week psychotherapy for almost seven months.

SECONDARY ISSUES

DELAY IN NOTIFICATION

At the hearing the beneficiary testified that it was not until March, 1983 that he was advised CHAMPUS coverage for one psychotherapy session per week would be retroactively denied to October 21, 1982. Part of the cause for this delay was because of the continued requests for additional documentation by the fiscal intermediary but be that as it may, the delay in notification cannot be the basis of my decision as to whether or not the benefits should be allowed. A prior final decision by the Assistant Secretary of Defense (Health Affairs) deals with concern because of an unreasonable delay in denying claims. "The appealing party contends that OCHAMPUSEUR unreasonably delayed denial of claims in this case. By this issue the appealing party attempts to raise the argument of estoppel against the government; however, such argument is without merit. Except for specific preauthorization cases as provided in the Regulation, CHAMPUS is an "at risk" program whereby the beneficiary obtains care and submits an after the fact claim for processing by the government or its fiscal intermediary. A beneficiary is expected to be familiar with the law and regulation with regard to CHAMPUS coverage and exclusions and may not rely on the delayed response as approval of a claim. Where treatment is a personal choice of the patient, CHAMPUS claims must be allowed or denied based on the law and regulation." OASD-HA 83-01

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 failed to meet this burden as the Regulation regarding frequency of outpatient psychiatric care is specific and there is no evidence that has been presented to show the patient's condition was so severe and complex as to require a frequency of therapy above the regulatory norm, even though it may well have been the treatment of choice between the patient and his physician.

SUMMARY

It is the recommended decision of the Hearing Officer that the outpatient psychotherapy rendered to the beneficiary from October 21, 1982 through May 21, 1983 be allowed at a frequency of two psychotherapy visits per week and that the third visit per week during this period of time was above the appropriate level of care and thus not medically necessary and should be denied under the provisions of the CHAMPUS Regulation, CHAPTER IV,C.3.i.

Dated this 25 day of July, 1984.

Hanna M. Warren

HANNA M. WARREN
Hearing Officer