DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

AURORA, COLORADO 80045

5 DEC 1984

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 84-31
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-31 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing parties are the participating providers of care, Sacred Heart General Hospital and River Road Medical Group. The appeal involves the question of CHAMPUS coverage of acute inpatient care for morbid obesity provided the beneficiary, the wife of an active duty member of the Oregon Army National Guard, from November 13, 1980, to July 7, 1981. The total hospital charge incurred by the beneficiary was approximately $57,772.39. The related physician's charge was approximately $1,084.50.

The hearing file of record, the tape of 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 the denial of CHAMPUS cost-sharing for inpatient care from November 13, 1980, through July 7, 1981, be reversed in part as follows: the CHAMPUS Hearing Officer recommended that the inpatient care provided the beneficiary from November 13, 1980, through March 11, 1981, be cost-shared under CHAMPUS, except for care related to diet counseling and exercise; however, the Hearing Officer recommended denial of CHAMPUS cost-sharing of the hospital care from March 12, 1981, until the date of discharge on July 7, 1981, because the care was for an excluded benefit (i.e., treatment of morbid obesity), was not medically necessary, and was above the appropriate level of care. The Hearing Officer further recommended that benefits for the attending services of the beneficiary's treating physician be allowed through March 11, 1981, and denied beyond that date because the services were related to a noncovered condition.

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

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendations of the Hearing Officer and Director, OCHAMPUS. In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence in this appeal. The findings are fully supported by the Recommended Decision and the appeal record. Additional factual and regulation analysis is not required. The Recommended Decision of the Hearing Officer is adopted and incorporated by reference as the FINAL DECISION.

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to allow CHAMPUS cost-sharing of the beneficiary's inpatient hospitalization at Sacred Heart General Hospital, Eugene, Oregon, from November 13, 1980, through March 11, 1981, except for care related to diet counseling and exercise, and to deny CHAMPUS cost-sharing of the inpatient hospitalization at Sacred Heart General Hospital from March 12, 1981, to July 7, 1981. The decision to deny CHAMPUS cost-sharing of the hospitalization from March 12, 1981, to July 7, 1981, is based on findings that the inpatient care was for an excluded benefit (i.e., morbid obesity), the care was not medically necessary, and the acute inpatient care was at an inappropriate level of care. Further, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) to allow CHAMPUS cost-sharing of the services of the treating physician through March 11, 1981, and to deny those services after March 11, 1981, because the services beyond that date related to a noncovered condition (i.e., morbid obesity). Therefore, the claims for inpatient care and related services from March 12, 1981, to July 7, 1981, and the appeal related to those claims are denied. The case is returned to the Director, OCHAMPUS, for review and appropriate recoupment action under the Federal Claims Collection Act. 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.

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

Beneficiary:

Sponsor:

Sponsor's SSN:

This case is before the undersigned Hearing Officer pursuant to the request for hearing by Sacred Heart General Hospital and River Road Medical Group, which was granted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). This hearing is being held pursuant to Regulation DOD 6010.8-R, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Chapter X, Sec. F, Paragraph 4, and Sec. H, Paragraph 2(b). The hearing was held on August 11, 1983, in Courtroom 406, U.S. Courthouse, 211 East Seventh Street, Eugene, Oregon. The beneficiary was not present nor did she have a representative in attendance. Sacred Heart General Hospital was represented by James R. Strickland, Esq. River Road Medical Group was represented by Stanley A. Boyd, M.D. OCHAMPUS was represented by Steven G. Plichta, Attorney/Advisor, Office of Appeals and Hearings. Also present as an observer was Bill Voharas, Attorney/Adviser, from that same office. The following persons were also present testifying as witnesses: Byron U. Musa, M.D., Karen Groth, Gwen Greer, and Ray Beaman. All of these witnesses are associated with Sacred Heart General Hospital.

HISTORY

Ms. entered Sacred Heart General Hospital on November 13, 1980, and she was discharged July 7, 1981. Her total hospital bill at Sacred Heart General Hospital was $57,772.39. The Fiscal Intermediary, Blue Cross of Washington and Alaska, paid claims for the first ninety days of in-patient care through February 10, 1981. The hearing file indicates that $15,217.53 was paid by CHAMPUS but Ms. Greer, from the Business Office of the hospital, stated that $18,343.39 was paid (Exhibit No. 54). A request for authorization for inpatient care beyond 90 days was made to OCHAMPUS and this request was denied. On informal review, dated August 25, 1981, the fiscal intermediary denied coverage for care for the period beyond 90 days and found that $1,415.30 of claims were erroneously paid within the first 90 days because they were related to charges for exercise and diet. A request for refund of this amount was requested and Exhibit No. 54 shows that this amount has been refunded to CHAMPUS by the hospital. OCHAMPUS made a reconsideration decision and denied inpatient care beyond 90 days because it was above the

appropriate level of care required to provide medically necessary service. The hosptial requested a formal review by OCHAMPUS and in that decision OCHAMPUS denied cost-sharing for the entire period of hospitalization from November 13, 1980 through July 7, 1981, except for the treatment of recurrent pneumonia. The record (Exhibit No. 11) indicates that care was allowed on the basis of the formal review decision from January 10, 1981, to February 10, 1981, for "isolation", the allowance being $998.00. Exhibit No. 54 shows $920.50 was paid by CHAMPUS to the hospital. Ms. Greer testified at the hearing that the hospital has elected to write off any finance charges and the total amount unpaid for Ms. 's hospitalization at this time is $39,923.80. No request for refund has been made for the $18,343.39 already paid by CHAMPUS for the first 90 days of hospitalization. The claim of River Road Medical Group is for hospital care rendered to Ms. from February 13, 1981 through July 5, 1981 in the amount of $1,027.50 and for nursing home visits on July 13th and July 31, 1981, for $57.00. This results in a total claim of $1,084.50. No amount has been paid on this claim.

ISSUES

The issue before this hearing officer is whether the medical care and services provided to at Sacred Heart General Hospital from November 11th through July 7th, 1981, are covered as a CHAMPUS benefit under the applicable law and regulation and were the services attendant to this care provided by Dr. Boyd of the River Road Medical Group from February 13th through July 31st a benefit of the CHAMPUS program or were they excluded from coverage as being services attendant to a non-covered condition.

LAW AND REGULATIONS

Regulation 6010.8-R is issued under the authority of and in accordance with Chapter 55, Title X, United States Code. It establishes uniform policy for the world-wide operation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Chapter IV of the regulation defines basic program benefits and paragraph A-1 provides in pertinent part as follows:

"Scope of Benefits - Subject to any and all applicable definitions, conditions, limitations and/or exclusions specified or enumerated in this regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies acquired in the diagnosis and treatment of illness or injury, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals or other authorized institutional providers, physicians and other authorized individual professional providers..."

Chapter II of the Regulation defines certain terms used in the scope of benefits and in paragraph 104 defines medically necessary: "Medically necessary means the level of services and supplies (i.e. frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury including maternity care. Medically necessary includes concept of appropriate medical care". Appropriate medical care is further defined in paragraph 14 to mean:

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

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

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

In addition to these general requirements there are certain specific exclusions from coverage under the CHAMPUS program and they are contained in Chapter IV of the CHAMPUS Regulation. The ones that are applicable to the issues involved in this hearing are contained in paragraph (g):

"Exclusions and Limitations: "In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other chapters of this Regulation, the following are specifically excluded from the CHAMPUS basic program;

(1) Not medically necessary - Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury.

(3) Institutional level of care - Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

(28) Obesity; Weight Reduction - Services and supplies related to obesity and/or weight reduction; the intestinal or stomach by-pass procedures, stomach stapling procedure, wiring of the jaws, or any procedure of similar purpose are also excluded regardless of the circumstances under which performed.

(43) Non-Medical Self Help - Educational services and supplies, training, non-medical self care/self help training and any related diagnostic testing or supplies.

(48) Exercise - General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider...

(69) Non-Covered Condition - All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment."

At the end of the specific exclusions there is the following paragraph:

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

The Department of Defense Appropriations Acts for 1980 and 1981 (PL96-154 and 96-527) contain the prohibition that no funds available for CHAMPUS under the provisions of section 1079(a) of Title 10, U.S. Code" shall be available for...(d) treatment of obesity when obesity is the sole or major condition treated".

EVIDENCE CONSIDERED

The Hearing Officer has carefully considered all the testimony given at the hearing, the arguments made and the documentary evidence described in the List of Exhibits, Nos. 1 through 54.

SUMMARY OF THE EVIDENCE

Before I begin a specific discussion of the testimony given at the hearing and the documentary evidence, I believe an over-view of the description of this patient and her medical problems given by all of the witnesses at the hearing would be helpful. Her treating physician was Dr. Boyd and at the hearing he stated if he had just been reading the hospital charts during peer review, he, too, might well have found that the hospital setting was not an appropriate treatment for this lady; that her problems and condition were so unique you had to have seen her and been involved in her treatment to really appreciate their severity. Ms. had been cared for at home by her family because her husband was not working and they received assistance from home health services through the State Social Services Department. She had been totally bedfast for somewhere between one and two years. Her medical condition had deteriorated and it was felt she had to be hospitalized for treatment. In order to do this, it required the assistance of the Fire Department and she was transported to the hospital in a moving van. Her weight at that time was estimated to be 800 to 850 pounds. They were unable to weigh her because there were no scales available and her condition was such that they could not get her to freight scales. When they arrived at the hospital she had to be wrapped in material to squeeze her together so she could pass through a hospital door, which is the width of a hospital bed. It was necessary to train the nursing staff to work with this

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consciousness) and pulmonary heart failure. Her skin ulcers needed daily debridement and she required a multi-disciplinary approach to try and improve her condition. They had a weekly conference regarding her hospitalization which was attended by all the specialists treating her and whether or not she required continued hospitalization was always discussed. In addition to this, he said they were constantly trying to get her into a position where she could be moved from the hospital, but no nursing home would accept her because of the medical problems she presented along with the practical problem of how they would care for her. He discussed the arterial oxygen measurements which were taken and his concern that she would develop pulmonary complications. He described in detail the necessity for her to be in isolation because of her infections and that no nursing home would admit or keep a patient with the kind of draining infectious wounds which she had. In response to my question concerning the findings which were the basis of the Colorado Foundation for Medical Care peer review, he stated Ms. did not have fainting spells but she clearly had pulmonary distress. He wasn't sure what all of the elements were of Pickwickian Syndrome and so he could not answer whether their conclusion regarding that condition was valid.

Another witness was Dr. Byron G. Musa who specializes in metabolic diseases and is Board certified in internal medicine and endocrinology. He testified there was no question in his mind that Ms. had a life threatening disorder at the time of her admission and through most of her hospitalization and described her as a "rare and unusual case". She had cellulitis which is an infection of the tissues of her body, draining wounds, was unable to ventilate, and had pulmonary hypertension. He testified she had massive infections on her legs caused by her skin breaking down, then cellulitis would then occur. He described cellulitis as an infection of the soft tissue caused by bacteria, an ulcer forms in the tissue and the infection spreads. He testified she was in isolation for most of her hospital stay because of her draining wounds, but he felt the major threat to her life was her respiratory problem. She was observed for heart failure which he felt was a very real possibility, but fortunately never developed. He hesitated to state one diagnosis because he said that it was something more than obesity and no single diagnosis could be made because her condition was so absolutely unique and unusual. In response to questioning as to why this patient could not have been treated in a nursing home or in some facility other than an acute hospital setting, Dr. Musa stated that he frequently went to nursing homes for medical visits and he had never seen a nursing home that could handle a patient with the multiple medical problems presented by Ms. He said any nursing home he was familiar with would require referral to an acute care facility of any patient with open draining wounds such as those of Ms. . He described her entire leg as red and weepy with large open areas which were ulcerated. The lesions varied from 2 inches to 6-12 inches with the area of infection being up to 3 inches deep with Staph. aureus and Pseudomonas. He said they

monitored the saturation of oxygen in her blood which required laboratory testing, gave her EKGs and oxygen, although the oxygen could have been given in a nursing home. He was absolutely certain that because of her extreme obesity she was in a life threatening situation and needed highly skilled nurses monitoring her and treating her draining infected wounds in an isolation setting.

Karen Gross testified as a witness for the hospital. She is a registered nurse with extensive experience dealing with nursing homes during her career. She subsequently received a law degree and is now employed by Sacred Heart General Hospital in the Quality Assurance Department. Her primary duty is to conduct patient reviews in order to determine whether medical care being supplied is appropriate. She brought with her a summary chart she had prepared on Ms. which was submitted as Exhibit No. 52. This chart lists direct care provided by nurses and only includes care which was done on a daily basis; any care which was not done daily was not included. An indirect care factor of 20%, or .2, is added to the daily direct care. The daily care hours were multiplied by seven days in a week and divided by 40 to arrive at how many full time equivalents were necessary for Ms. 's care. This number is shown at the very bottom number in the chart and varies from 2.6 full time equivalents at the beginning of her hospital stay down to one FTE just before she was discharged. She stated that a nursing home usually has a maximum of .3 to .5 full time equivalents per patient and it is well known that any care needing more than .5 full time equivalents per patient is a level of care that is not available in a nursing home. She testified that Ms. was in isolation at Sacred Heart General Hospital most of the time of her hospitalization because she had wounds infected with Staph. aureus and Pseudomonas. In addition she required constant highly skilled nursing care and monitoring. The staff in a nursing home could not have inserted a foley catheter in this patient because of her immense size and the medical problems it presented. She was cyanotic a great deal of the time and complained of chest pains which were constantly monitored. On the special care unit she was on, the skilled registered nurses did the wound debridement. This special care unit had specially trained nurses providing the care and part of that care was the insertion of the foley catheter because of her incontinence and draining onto her open sores. The wound and skin isolation care required highly skilled care as did the debridement and technical monitoring of her pulmonary problems.

Another witness from the hospital was Gwenn Greer, who is in the hospital accounting department. I don't believe a lengthy discussion of her testimony is necessary. I mentioned at the beginning of this decision the figures she gave as the total cost of Ms. 's care, the amount paid by CHAMPUS and the amount that has been refunded to CHAMPUS. She submitted Exhibit No. 54 which is self-explanatory as to the charges and payments.

Mr. Ray Beeman is the hospital administrator and his testimony was very brief. He stated he was concerned about Ms. from the time of her admission because of the large cost for her medical care. Even if CHAMPUS had allowed the entire amount, the hospital would have to bear the 25% remainder because Ms. was unable to pay for her own care. He said he was constantly trying to get the doctors to move her from the hospital, but that he never met with any success in that because all the physicians who were treating her felt it was essential that she remain in the acute hospital setting for treatment of her medical problems.

Ms. Gross brought with her some material from the Utilization Review Department which I have examined (Exhibit No. 51). It appears to start with the admission and diagnosis of massive obesity and extensive decubitus ulcerations: "Patient completely unable to care for herself". The first notes show they were attempting to find a facility to accomodate the patient. The notes on January 29th show "skin ulcerations do not seem to be healing, covered with necrotic debris and large ulcer 2 inches deep", and concludes, "urine loaded with pus". This is shown in the patient update typed 2/2/81. In this patient update it states "It is becoming apparent that this patient will be here for a better part of a year, if not longer". The handwritten notes on February 11th show, "Welfare has now decided to pay for 2 nursing home beds for this patient - she still has dirty wounds". The notes in this exhibit also show that she was discharged from isolation on March 11, 1981. It is a little unclear from these notes whether she was actually transferred. They indicate that maybe after her isolation discharge they only charged her for a private room and not the extra charge for the isolation. Exhibit No. 51 shows a dictation by Dr. Hugh B. Johnston on June 1st, 1981 saying the patient was seen for utilization review at the recent updating and he had reviewed the charts, doctors notes and consultations back through January. He said that at the time of his report there were no "urinary, ulcer or acute metabotic problems" and he felt she could have been cared for in a nursing home as of mid-May.

This claim was submitted on May 6th, 1981, to the Colorado Foundation for Medical Care for peer review and recommendation. The information was to be used by OCHAMPUS to decide if inpatient hospitalization would be allowed beyond the 90 days already paid. Page 3 of of this peer review (Exhibit No. 6) gives the primary diagnosis as morbid obesity. In the history of illness, it states: "Has been extensively studied with no significant endocrine or metabolic abnormality found. Has significant psychological problems, but surprisingly free of medical complications. Has not had pulmonary problems, syncopal attacks or evidence of Pickwickian Syndrome...Hospitalized for care of skin breakdown and celulitis, dietary control, management of infections". It goes on to say in the physical findings that she is bedridden because of her weight and, considering her size and weight, "The extent of her ulcerations might be considered rather minimal". Page 1 of this peer review report states: "We

recognize that this is an extreme case of morbid obesity representing unusual circumstances, but we have not seen where acute care facilities are medically necessary. At best the patient requires care in a nursing home rather than an acute care hospital". This peer review was done by two specialists in internal medicine and the recommendations were that the acute care hospital setting was not the appropriate level of care and the patient could be cared for adequately in a nursing home. They felt the patient treatment or management plan was appropriate for the diagnosis but that an acute care hospital was not necessary for the administration of the medical plan. They found the patient was totally bedridden, needed assistance and her disability would continue and be prolonged but that she did not need care in an acute care hospital. In response to the question of the active and specific medical and surgical treatment being received to enable her to function outside of the protected, monitored and controlled environment, they discuss only the hope, intent and goal of reducing the patient's weight so that she could be ambulatory. At no place in this peer review report do they mention or discuss the fact that she was in isolation in the hospital, the care required for this and the other specific medical problems which were discussed at the hearing.

ANALYSIS OF THE EVIDENCE

Both doctors who testified at the hearing described this as an unusual and rare case, and because of its uniqueness, the factual determination necessary for me to make my decision has been difficult. Because of the many problems suffered by Ms. , she required a multi-disciplinary treatment program and presented some needs for care that are clearly not a benefit of the CHAMPUS program and others that might be covered as a benefit, depending on the circumstances of the patient, and the severity of the symptoms. It is clear that the United States Congress in passing appropriations to fund CHAMPUS benefits is very concerned that no benefits be paid for the treatment of obesity. The hearing file and the testimony given at the hearing though makes it clear to me that when Congress states treatment of obesity is not covered "when obesity is the sole or major condition treated", that prohibition does not apply to Ms. 's care, certainly at the beginning of her hospitalization. Her treatment clearly was not solely for obesity and the decision has to be made as to when the treatment of obesity became the major condition treated. In addition, I must decide whether from the very beginning of her care at Sacred Heart General Hospital, the level of care provided by this acute care facility was above that which was medically necessary or appropriate for her physical condition. This is the position that is taken by OCHAMPUS in denying benefits for the entire inpatient hospitalization from November 13, 1980 through July 7, 1981, except for the benefits allowed for treatment of recurrent pneumonia. This decision is based upon the peer reviewer's determination that the medical problems presented by Ms. did

not require care in an acute hospital setting and thus her hospitalization was above the appropriate level of care which was medically necessary for her treatment.

Both Dr. Musa and Dr. Boyd, who testified at the hearing, were convinced that, at the time Ms. was admitted to the hospital, she was in a life threatening situation, and both of them agreed there was really no name for it. Dr. Musa said morbid obesity is not really the right name but they called it that for the lack of anything better. He said morbid obesity is a normal person who can't control their weight gain and gets heavier and heavier, usually in the range of 300 to 500 pounds and surgery is performed in an attempt to curb their weight gain. He said that although this patient could not control her weight and was getting heavier and heavier, she was beyond what would normally be called a diagnosis of morbid obesity. There was just nothing in the medical literature or their experience to give them a great deal of guidance in how to deal with this patient, although both of them reported a patient who was even heavier at the University of Washington and they had been in contact with the physician treating that patient and had attempted to establish some sort of correspondence or "pen-pal" dialogue with Ms. and that patient. Dr. Musa testified that he felt the most life threatening concern with this patient was her pulmonary problem. She was almost unable to ventilate at the time she entered the hospital. He couldn't tell why; partially it was mass, but he felt it was partially a central nervous system condition because she just lacked ventilative drive. This chronic lack of oxygen raised her blood pressure and caused pulmonary hypertension which ultimately leads to heart failure. He felt it was absolutely essential that she be in a special care unit, observed by skilled registered nurses to avoid hypoxia and loss of consciousness and to be monitored for saturation of oxygen and carbon dioxide in her blood. She also complained of chest pains. He testified that the monitoring of arterial oxygen was done frequently at the beginning of her hospitalization and was an extremely important element of her care. This was another element of care that could not have been provided in a nursing home. Dr. Musa also testified she had an infection of the tissues of her body and cellulitis. At the time of her admission, her entire legs were red and weepy and she had large open areas which were ulcerated with the skin missing. This was really caused by her massive size and lack of oxygen and her skin had broken down which resulted in an invasion of bacteria producing toxin which Dr. Musa said endangered her very existence. He testified she could have died from this continued infection and, in his opinion, she could not live without treatment. It was necessary to keep her in isolation as long as the wounds were draining and his extensive experience in nursing homes was that none would take her while she had open draining wounds. It was his testimony that the level of care required for treatment of her skin infections and draining leisons was way beyond any care he had ever seen available in any nursing home.

Dr. Boyd also described in great detail the cellulitis she suffered and the chronic infection of her skin which was treated with antibiotics, hot packs, and sterile dressings. He reported that periodically she would have a recurrent pneumonia and had chronic urinary tract infection. She was incontinent and it was necessary to insert a foley catheter to keep her from contaminating her own open wounds (Ms. Gross testified in her extensive experience there were no personnel adequately trained in a nursing home to insert a foley catheter into a patient that was this obese). In addition to the isolation techniques necessary to treat Ms. , the wounds needed to be debrided and Dr. Boyd stated this is always done by a skilled registered nurse or a physician. He also discussed the pulmonary problems that she was having and agreed with Dr. Musa regarding the necessity for arterial oxygen monitoring. The lack of oxygen in her circulation also contributed to the skin breaking down which contributed to the recurrent infections. Dr. Boyd felt very strongly that she especially needed the skilled monitoring which can be provided in a hospital setting amd is totally unavailable in a nursing home. He stated she also needed the consultation with other doctors (or the team approach) which was the only way he felt she could ever survive.

Whether the multi-disciplinary approach and the need for skilled monitoring required that she be in a hospital setting is difficult for me as a layman to evaluate when there are opinions of two physicians who did the peer review stating this did not require a hospital setting. I do though find Dr. Musa's and Dr. Boyd's testimony persuasive regarding the need to [illegible] pulmonary function and the need for skilled technical isolation care to manage her skin infections. Both of them stated categorically that no nursing home would have taken any patient, no matter what their size, with the kinds of open draining wounds possessed by Ms. . In making this decision I am aware that part of her hospital treatment was, of course, directed towards treatment of her obesity, but it was not the sole treatment, nor a major part of the treatment, in the beginning of her hospitalization. Dr. Boyd stated at the hearing that treating her medical problems and not treating her obesity would be like treating the problems and complications of diabetes without administering insulin.

As Hearing Officer I must carefully consider all of the evidence regarding this claim, not only the testimony of Ms. doctors but the material in the hearing file. I have gone over in detail the peer review report which appears to have been used primarily as the basis for the formal decision made by OCHAMPUS to deny coverage for the care. After hearing Dr. Musa and Dr. Boyd describe Ms. at the hearing, it became clear to me that the record I had read previous to the hearing did not adequately describe the enormity of the problems presented by this patient and the type of care she needed and received. Even Dr. Boyd at the hearing stated "If I had been a peer reviewer looking at the hospital record, I might well have denied benefits for hospital care myself without having seen the patient." It

is unclear from the file what records were available to the internists who did the peer review for the Colorado Foundation for Medical Care. I cannot tell whether they read the entire hospital record or only the reports which were sent by some treating physicians at the time the authorization for care beyond 90 day hospitalization was requested. I believe it is the latter because the peer review request says "Medical records available for review". The case summary seems to rely to a great extent on language from the report of Dr. Musa, which was dated February 11, 1981. Most of the medical reports submitted to OCHAMPUS were approximately at that time; which was three months into Ms. 's hospitalization. Dr. Musa's report is of concern to me because he describes her as "surprisingly free of medical problems" and goes on to say "the examination was not remarkable and there are no pulmonary findings". I specifically asked Dr. Musa about this at the hearing and he said this report was written after she had been treated for three months and when his report states she is free of medical complications and there are no pulmonary findings, he did not mean to imply this was true at the beginning of her hospitalization and also his report was being written as an endocrinologist and he was not reporting as to her pulmonary function. He testified that their worst fears regarding Ms. fortunately did not occur and his report would have been a very different one if it had been dictated at the time of her admission. He said he was writing the report as an endocrinologist and focused on problems in that area. This appears to be what was done by each of the doctors who wrote the reports in Exhibit No. 3 in that they were really reporting from their area of expertise.

There were frequent conferences with the physicians providing care and a utilization review examination on a monthly basis. Transfer was constantly discussed in these meetings. Early in her hospitalization, Dr. Boyd's notes state "investigating possibility of transfer". He testified at the hearing that he tried to transfer her to the medical school teaching hospital but they refused to take her. It was the consensus of opinion at these conferences that she should be kept in isolation and she was not discharged from isolation until March 11, 1981. The utilization notes state in December "transfer depends on skin Staff".

The testimony at the hearing was clear that a nursing home would not accept this patient and I do not believe that is controverted by any of the evidence in the hearing file. Although that fact was certainly a practical consideration that caused the hospital to do considerable investigating regarding her subsequent care, it cannot be the basis for my decision. There is nothing in the CHAMPUS Regulation providing coverage will be extended to patients for care at a higher level than is medically necessary simply because care at a lower level is not available.

I have carefully examined the nursing notes and hospital records and conclude that, at the point Ms. was discharged from isolation the level of care provided to her became more directed towards treating her obesity. I am aware she had one flare-up of ulcerations subsequent to that discharge but it appeared relatively brief and not too difficult to manage; at least it did not necessitate her being transferred back to isolation care. Although Dr. Boyd testified at the hearing that he felt she was still medically unstable on March 25th, there is little in the hospital charts to demonstrate the basis for this conclusion and Dr. Boyd subsequently testified that he just could not say when it became medically unnecessary to have Ms. treated with the skilled level of nursing care provided in the hospital. My examination of the records shows the treatment of pneumonia also occurred during the period of time that Ms. was in isolation.

There are hosptial statements contained in the hearing file showing that charges were made for diet counseling and exercise. Dr. Boyd testified at the hearing that the diet counseling was more than just discussion of calories and was a specific plan of managing Ms. 's whole eating pattern and what it meant to her. As to this diet counseling and exercise, I agree with the determination made by OCHAMPUS. The specific Regulatory provision quoted above in this decision reflects the concern of Congress that charges for services related to treatment of obesity be excluded as a benefit from the CHAMPUS program.

This hearing also involves claims for services of Ms. 's attending physician from January 29th through July 5th, 1981. Because the CHAMPUS Regulation is clear in excepting from coverage all services and supplies related to a non-covered condition or treatment, the charge for services of Dr. Boyd after March 11, 1981, must be denied.

FINDINGS OF FACT

1. Ms. was admitted to Sacred Heart General Hospital on November 13th, 1980, and was discharged on July 7th, 1981.

2. The treatment of her skin infection was medically necessary and required inpatient hospital care through March 11th, 1981.

3. Inpatient hospitalization was appropriate and medically necessary for treatment of her urinary tract infection including the insertion of a foley catheter, treatment of recurrent pneumonia, and observation and monitoring of pulmonary function. This medical necessity continued through March 11, 1981.

4. Hospital care rendered to Ms. at Sacred Heart General Hospital after March 11th, 1981, was primarily for treatment of obesity and above the appropriate level of care which was medically necessary.

5. Services rendered to Ms. for diet counseling were directed in major or sole part to the treatment of her obesity and are not covered as benefits under the CHAMPUS program.

6. Exercise treatments given to Ms. during her hospitalization were also directed in sole or major part towards the treatment of her obesity and excluded as benefits under the CHAMPUS program.

7. The physician care provided to Ms. by Dr. Boyd subsequent to March 11, 1981, is not eligible for coverage as a benefit under the CHAMPUS program because it relates to a non-covered condition.

RECOMMENDED DECISION

It is the recommended decision of the Hearing Officer that the hospital care rendered to Ms. at Sacred Heart General Hospital be allowed from November 13, 1980 through March 11, 1981, except for the care for diet counseling and exercise and that the hospital care from March 12th until the date of her discharge on July 7th, 1981, be denied as not medically necessary and above the appropriate level of care.

It is further recommended that benefits for the attending services of Dr. Boyd be allowed through March 11, 1981, and denied beyond that date as services attendant to a non-covered condition.

Dated this 27th day of September, 1983.

Hanna M. Warren
Hearing Officer

HMW/db
cc: Appeals & Hearings