ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

DEC 5 1984

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 84-24
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-24 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing parties include the beneficiary, the daughter of an active duty member of the U.S. Navy; the professional provider of care, the Metropolitan Psychiatric Group; and the institutional provider of care, the Psychiatric Institute of Washington, DC.

This appeal involves a question of CHAMPUS coverage of psychiatric services provided while the beneficiary was an inpatient at the Psychiatric Institute of Washington. The episode of care is from October 5, 1981, the date of admission, to discharge on May 7, 1982. The amount billed for professional services by the Metropolitan Psychiatric Group was $10,580.00, and the amount billed for inpatient services by the Psychiatric Institute of Washington was $96,467.45.

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 Recommended Decision that the OCHAMPUS Formal Review Decision denying CHAMPUS cost-sharing for the inpatient hospitalization and related psychiatric treatment after November 5, 1981, be reversed; that inpatient hospitalization and related psychiatric treatment should be cost-shared by CHAMPUS for the period of October 5, 1981, through March 25, 1982; and that CHAMPUS cost-sharing should be denied only for inpatient hospitalization and related psychiatric treatment received from March 26, 1982, to May 7, 1982. The Hearing Officer, however, did recommend that the OCHAMPUS Formal Review Decision limiting CHAMPUS cost-sharing only to two 1-hour individual psychotherapy sessions per month from November 6, 1981, through May 7, 1982, be upheld.

The Director, OCHAMPUS, recommends partial rejection of the Hearing Officer's Recommended Decision. The Director, OCHAMPUS, concurs with the Hearing Officer's finding that the professional

provider (i.e., Metropolitan Psychiatric Group) failed to furnish adequate documentation of the psychotherapy in dispute; however, it is the Director's opinion that, consistent with prior FINAL DECISIONS, such a finding requires a determination that the claims for psychotherapy be denied CHAMPUS cost-sharing. Further, it is the Director's opinion that the record does not establish that an acute inpatient setting was the required level of care after the first 30-days of hospitalization; therefore, the beneficiary's inpatient confinement from November 5, 1981, to May 7, 1982, was not medically necessary. The Director, OCHAMPUS, recommends issuance of a FINAL DECISION which denies CHAMPUS coverage of the entire episode of inpatient care from November 5, 1981, to May 7, 1982, as well as all claims for therapy furnished by the professional providers from October 5, 1981, to May 7, 1982.

Under DoD 6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject the Hearing Officer's Recommended Decision. In case of rejection, a FINAL DECISION may be issued by the Assistant Secretary of Defense (Health Affairs) based on the appeal record.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendation of the Director, OCHAMPUS, to deny CHAMPUS cost-sharing for the entire episode of inpatient care after November 4, 1981, and all claims for therapy sessions from October 5, 1981, to May 7, 1982. The Hearing Officer's Recommended Decision is, therefore, rejected, in part, as not supported by the record and as not consistent with prior FINAL DECISIONS or the Department of Defense Regulation which governs the administration of CHAMPUS.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS cost-sharing of the inpatient care from November 5, 1981, to May 7, 1982, and all psychotherapy from October 5, 1981, to May 7, 1982. The decision to deny coverage of the care in question is based on findings that the inpatient hospitalization after November 4, 1981, was not established as being medically necessary or at the appropriate level of care, and the psychotherapy in dispute was not documented. Only the inpatient care from October 5, 1981, to November 5, 1981, may be cost-shared under CHAMPUS as medically necessary care.

FACTUAL BACKGROUND

The beneficiary was admitted to the Psychiatric Institute of Washington, DC, on October 5, 1981, as a result of her refusal to attend school, family problems, peer relation problems, and self image problems. The record shows that the beneficiary refused to attend school and had been seen by school counselors and by Dr. Gemmeli of the Bethesda Naval Hospital. Dr. Gemmeli saw her for several sessions over a 1-week period as an outpatient before she was referred to the Psychiatric Institute of Washington. As

noted by the Hearing Officer, the beneficiary had experienced rebelliousness, a 40-pound weight gain, tantrums, truancy, and threats to run away for about 1 year prior to her admission. She had begun to withdraw from her family and friends. She also experienced inability to control her aggressive impulses, particularly toward her younger brother.

At the time of her admission, the beneficiary was 13 years old and in the eighth grade. Initially, the beneficiary was admitted on October 5, 1981, to a closed adolescent unit for a 30-day diagnostic evaluation. Upon completion of the initial 30-day stay, the beneficiary was transferred to an open adolescent unit at the Psychiatric Institute.

CHAMPUS claims for inpatient care from October 5, 1981, through December 31, 1981, were filed with the CHAMPUS Fiscal Intermediary. The fiscal intermediary allowed cost-sharing of inpatient care through December 31, 1981, the entire period covered by the claims, based on three medical reviews, in part, as follows:

Dr. Warren Johnson, a psychiatrist, opined:

> "The care appears to have been medically necessary. Inpatient care was appropriate. 88 days should be the upper limit of inpatient care necessary. A severe separation anxiety disorder and histrionic personality disorder would be requirement of hospitalization."

Dr. Johnson recommended the claim for 88 days be approved as appropriate.

Dr. William Noah, a child psychiatrist, stated:

> ". . . to use the hospital for a diagnostic evaluation seems warranted . . . the report does not justify 88 days of hospitalization . . . I think the length of stay excessive. . . ."

Dr. Noah recommended approval for 30 days.

Dr. Roy Coleman, a psychiatrist, concluded the information provided was not adequate and did not give his opinion of the medical necessity of the admission.

The fiscal intermediary, based on these reviews, concluded the inpatient stay was excessive, but nevertheless, allowed benefits through December 31, 1981. Additional CHAMPUS claims for inpatient care received after December 31, 1981, were denied CHAMPUS cost-sharing by the fiscal intermediary, and the sponsor

was informed of the determination in a letter dated February 24, 1982.

An Informal Review of the denied claims was requested by the sponsor in a letter dated March 11, 1982. The fiscal intermediary's April 21, 1982, Informal Review concluded, "the original determination was correct," however, the Informal Review went on to state:

> "However, due to the lengthy peer review and appeals process, it has been determined the retroactive denial places many hardships on both the beneficiary and the family.
>
> "Therefore, benefits will be [an] additional 30 days after the letter informing you of the Peer Review Decision. According to this, inpatient services will be terminated as of March 24, 1982." (Emphasis in original.)

As a result of this decision, the fiscal intermediary issued a CHAMPUS payment of $9,240.00 of the Metropolitan Psychiatric Group bill of $10,580.00, and $78,103.14 of the Psychiatric Institute of Washington bill of $96,467.45.

The sponsor requested reconsideration of the decision to deny CHAMPUS cost-sharing of inpatient care after March 24, 1982. In a June 15, 1982, letter, he stated that:

> "The beneficiary was discharged on May 7, 1982, two weeks after receipt of the second rejection for further consideration . . . in spite of the fact that it was the opinion of the doctor and other staff that she was not quite prepared. . . ."

Following a similar request for reconsideration and correspondence from Dr. Bates (a psychiatrist with the professional group who was the beneficiary's primary therapist), the fiscal intermediary on October 12, 1982, issued its Reconsideration Decision denying the appeal. The decision again stated that CHAMPUS cost-sharing was allowed for care received until March 24, 1982, due to the time period involved with peer review and the two levels of appeal. The matter was then appealed by the beneficiary to OCHAMPUS.

Before issuing its Formal Review Decision, OCHAMPUS obtained a peer review from the American Psychiatric Association. The medical reviewer, Dr. James A. Margolis, a child psychiatrist, opined, in part:

> ". . . the failure [emphasis in original] of outpatient therapy consisted of only 3 or 4 sessions. No attempt was made prior to admission to explore an alternative school

program, partial hospitalization or intensive family therapy.

"The medical records consisted mainly of POMR (Problem Oriented Medical Records), S.O.A.P. written by psychiatric technicians and nursing staff. The only progress reports by a psychiatrist were monthly typewritten reports. Again using the POMR approach. There were no [emphasis in original] ongoing assessments of the mental status or reports of individual psychotherapy sessions. . . .

"The program seemed well organized. . . . the level of care, however, seemed more like an RTC rather than acute hospital. . . .

* * *

"It would appear that she was ready for discharge by mid-March 1982. However, I challenge the need for the entire hospitalization, especially after an initial evaluation of one month. If I understand the Discharge Summary correctly, she was to continue in the hospital school program. Why was this not tried initially or after an appropriate (1 month) inpatient evaluation.

"1. Was the inpatient hospitalization and psychiatric treatment from October 5, 1981 through May 7, 1982, medically necessary treatment, considering this patient's condition (that is, adequate for the diagnosis and treatment of illness or injury)?

"No. First of all I do not feel she had an adequate trial of outpatient therapy nor was there a trial of a lesser level of care (e.g. day treatment). At the same time, considering her hostility toward her family and poor self-esteem, I would certainly feel a 30 day evaluation was justified.

"2. If the entire hospitalization and psychiatric treatment was not medically necessary treatment for this patient's condition, at what date was treatment not medically necessary?

"Yes. As stated above, I feel that a real trial at outpatient or day treatment should have been carried out by the 30th day.

* * *

"4. Was the inpatient hospitalization and psychiatric treatment provided at the appropriate level of care (that is, at the level adequate to provide the required medical care)?

"No. The first 30 days may have been at an appropriate level; the remainder was at a day treatment (partial hospital) or RTC level of care. She could have gone home, but did not want to." (Emphasis in original.)

Based on the peer review, the OCHAMPUS Formal Review Decision, issued July 1, 1983, found "the inpatient hospitalization and related psychiatric treatment was not appropriate medical care and was not medically necessary treatment after November 5, 1981." The Formal Review Decision, however, authorized two 1-hour therapy sessions per month for CHAMPUS cost-sharing; all other therapy sessions were denied CHAMPUS cost-sharing because there was insufficient documentation to support the claims. The beneficiary, the professional provider, and the hospital all appealed this decision and requested a hearing.

A hearing was held at the Psychiatric Institute of Washington, DC, on November 18, 1983, before CHAMPUS Hearing Officer, Suzanne S. Wagner. Present at the hearing were: the sponsor; the sponsor's wife; Dr. Joseph Novello for both the Metropolitan Psychiatric Group and the Psychiatric Institute of Washington; Don Silver, Administrator of the Psychiatric Institute of Washington; Martha Vayhinger, M.S.W.-the current therapist for the beneficiary; Wanda Miller, an Assistant Administrator of the Psychiatric Institute; and Katie Campbell as an observer from Congressman McKernan's office. The Hearing Officer has submitted her Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are (1) whether sufficient information exists to establish the medical/psychological necessity and appropriateness of the beneficiary's psychotherapy received from October 5, 1981, to May 7, 1982; (2) whether sufficient information exists to establish the medical/psychological necessity and the appropriateness of the beneficiary's acute inpatient hospitalization from October 5, 1981, to May 7, 1982; and, (3) whether the professional provider's billings for the beneficiary's psychotherapy were accurate and proper CHAMPUS claims.

Information Necessary to Support CHAMPUS Claims

As an initial point, it is important to note that the Hearing Officer's 49 page Recommended Decision accurately summarizes a voluminous record and presents a cogent evaluation of the available evidence. The primary issues in this appeal, however, address the level of information or documentation required by the CHAMPUS regulation and prior FINAL DECISIONS to support a CHAMPUS claim, and the effect of any failure of the hospital or the professional provider to maintain and/or furnish the required level of information. The Hearing Officer addressed the failure of the professional provider to adequately document the psychotherapy claims; however, the precise documentation needed in the acute inpatient hospitalization setting was not specifically discussed. It is, therefore, deemed essential in this FINAL DECISION to address the CHAMPUS requirements for information to support inpatient mental health care and the inadequacies of the records of the hospital and professional provider in this case in meeting the informational requirements.

The CHAMPUS regulation, DoD 6010.8-R, chapter IV, A.1., defines the scope of CHAMPUS benefits 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. . . . Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional providers. . . ."

Chapter IV, A.5, provides:

> "Right to Information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS and/or its CHAMPUS Contractors shall be entitled to receive information from a physician or hospital or other person, institution, and/or organization . . . providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary and shall be necessary for the accurate and efficient administration of CHAMPUS benefits . . . Before an individual's claim of benefits will

> be adjudicated, the individual must furnish to CHAMPUS that information which may reasonably be expected to be in his or her possession and which is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim."

Institutional benefits are set forth in section B of chapter IV of the Regulation. The Regulation provides in addressing institutional benefits that:

> "General. Benefits may be extended for those covered services and supplies described in this Section B of this CHAPTER IV, provided by a hospital or other authorized institutional provider (as set forth in CHAPTER VI of this Regulation, 'Authorized Providers'), when such services and supplies are ordered, directed, and/or prescribed by a physician and provided in accordance with good medical practice and established standards of quality. Such benefits are subject to any and all applicable definitions, conditions, limitations, exceptions, and/or exclusions as may be otherwise set forth in this or other CHAPTERS of this Regulation." DoD 6010.8-R, chapter IV, B.1.

Chapter VI of the Regulation addresses authorized providers. Section B.4.b. of chapter VI in recognizing certain psychiatric hospitals as authorized institutional providers states:

> "In order for the services of a private psychiatric hospital to be covered, the hospital must comply with the provisions outlined in Paragraph B.4. of this CHAPTER VI except that Subparagraph B.4.a.(9) does not apply. In the case of private psychiatric hospitals, all must be accredited by the JCAH in order for their services to be cost-shared under CHAMPUS." DoD 6010.8-R, chapter VI, B.4.b(2). (Emphasis in original)

The Regulation further provides at Chapter VI, B.3., that:

> "Factors to be considered in determining whether CHAMPUS will cost-share care provided in a psychiatric hospital include, but are not limited to, the following considerations:
>
> * * *

> "(b) Can the services being provided be more economically provided in another facility or on an outpatient basis."

Chapter VI, B.4.a.(2), includes the requirement that:

> "[The hospital] maintains clinical records on all inpatients (and outpatients if the facility operates an outpatient department or emergency room)."

This requirement applies to all acute care hospitals and, by reference, to psychiatric hospitals.

The Regulation in addressing professional services provides in chapter IV, C.1., that:

> "General. Benefits may be extended for those covered services described in this section C of this CHAPTER IV, which are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers. . . . 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.
>
> * * *
>
> "a. Billing Practice. To be considered for benefits . . . [S]uch billings must be fully itemized and sufficiently descriptive, to the satisfaction of CHAMPUS."

The Regulation specifically addresses psychiatric procedures in chapter IV, C.3.i.:

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

> combination of both, is being rendered to an inpatient on an ongoing basis (i.e., non-crisis intervention), benefits are limited to no more than five (5) one-hour therapy sessions (in any combination of group or individual therapy sessions) in any seven (7) day period."

Chapter VII, section A provides:

> "The Director, OCHAMPUS (or a designee), is responsible for assuring that benefits under the CHAMPUS Program are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted which provides sufficient information as to beneficiary's identification, the medical services and supplies provided, and double coverage information, in order to permit proper, accurate and timely adjudication of the claim. . . ."

In chapter VII, B.2., "patient treatment information" requires in subsection i., that:

> "Physicians or Other Authorized Individual Professional Providers. For services provided by physicians (or other authorized individual professional providers), the following information must also be included:
>
> "(1) Date of each service.
>
> "(2) Procedure code and/or narrative description of each procedure/service for each date of service.
>
> "(3) Individual charge for each item of service or each supply for each date.
>
> "(4) Detailed description of any unusual complicating circumstances related to the medical care provided which the physician or other individual professional provider may choose to submit separately."

The Regulation also provides for a "right to additional information:"

> "As a condition precedent to the provision of benefits under this Regulation, OCHAMPUS . . . may request and shall be entitled to receive information from a physician or hospital or other person, [or]

> institution . . . providing services or supplies to the beneficiary. . . . Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to, a beneficiary and as shall be necessary for the accurate and efficient administration of CHAMPUS benefits." DoD 6010.8-R, chapter VII, B.4.

The Regulation further provides that "the 'burden of proof' is on the appealing party affirmatively to establish by substantial evidence, the appealing party's entitlement under law and this Regulation to the authorization of CHAMPUS benefits or approval as an authorized provider." DoD 6010.8-R, chapter X (amendment 19), 48 Federal Register 10311, March 11, 1983.

The above, rather detailed quotations from the Regulation are necessary both to establish the regulatory basis for the CHAMPUS documentation requirements and because of Dr. Novello's (the providers' representative at the hearing) characterization of the problems of documentation in this appeal as a technicality.

The CHAMPUS program does not operate in a vacuum; the CHAMPUS documentation requirements are in keeping with requirements of the profession. For example, at the hearing Dr. Novello repeatedly made the statement that the Psychiatric Institute was in compliance with JCAH standards. Since the CHAMPUS regulation requires private psychiatric hospitals to be accredited by the JCAH, the JCAH standards establish the minimum records necessary for documentation of CHAMPUS claims. The jurisdiction under which the provider(s) is licensed, however, may add further requirements.

The JCAH's Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities (1981 edition) sets forth specific requirements relating to medical records and progress notes. (Hereinafter, it will be generally referred to as the JCAH Manual.) The JCAH Manual in the introductory pages titled "Using the Standards" states:

> "This Manual contains what JCAH currently considers to be the most useful and appropriate standards for evaluating and improving the quality of care provided to . . . child and adolescent psychiatric . . . patients. Except as indicated in the Table of Applicable Standards in Appendix A of this Manual and in the standards themselves, the standards are applicable to all services, units, programs,

and facilities providing services to the aforementioned patients."

Standard 15, which deals with patient records, provides:

"15.1. The facility shall maintain a written patient record on each patient.

"15.1.1. The patient record shall describe the patient's health status at the time of admission, the services provided, and the patient's progress in the facility, and the patient's health status at the time of discharge.

"15.1.2. The patient record shall provide information for the review and evaluation of the treatment provided to the patient."

Standard 18 addresses treatment plans and provides:

"18.1. Each patient shall have a written, individualized treatment plan that is based on assessments of his or her clinical needs.

* * *

"18.1.3.2.1. The master treatment plan shall contain objectives and methods for achieving them.

* * *

"18.1.11. The treatment plan shall describe the services, activities and programs planned for the patient and shall specify the staff members assigned to work with the patient.

"18.1.12. The treatment plan shall specify the frequency of treatment procedures.

"18.1.13. The treatment plan shall delineate the specific criteria to be met for termination of treatment. Such criteria shall be a part of the initial treatment plan."

Standard 18.2 addresses progress notes. It provides:

"18.2. Progress notes shall be entered in the patient's record and shall include the following:

"a. documentation of implementation of the treatment plan;

> "b. documentation of all treatment rendered to the patient;
>
> "c. chronological documention of the patient's clinical course;
>
> "d. description's of each change in each of the patient's conditions; and
>
> "e. descriptions of the response of the patient to treatment, the outcome of treatment, and the response of significant others to important intercurrent events.
>
> * * *
>
> "18.2.7 Progress notes shall be used as the basis for reviewing treatment plans."

Standard 18.3. provides "Multidisciplinary case conferences shall be regularly conducted to review and evaluate each patient's treatment plan and his or her progress in obtaining stated treatment goals and objectives."

The JCAH Manual defines an "inpatient program" as "Programs that provide services to persons who require an intensity of care that warrants 24-hour supervision in a hospital or other suitably equipped setting." The Manual defines "shall" as "used to indicate a mandatory standard."

The standards set forth in the JCAH Manual are the applicable standards for the period of care covered by this appeal. The standards dealing with records have been carried forward in the JCAH's Consolidated Standards Manual/83 for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities.

More importantly, these record requirements are not new. The JCAH's Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism and Drug Abuse Programs (1979 edition) provide for, with minor differences, essentially the same requirements.

For example, standard 12.1 in the 1979 edition required "a written patient record shall be maintained for each patient." The standard went on to provide:

> "12.1.4. The patient record shall substantiate the adequacy of the assessment process as the basis for the treatment plan.
>
> "12.1.5. The patient's record shall facilitate continuity of treatment, as well as facilitate the determination at a future

> date, of the patient's condition and what treatment was provided at any specified time.
>
> "12.1.6. The patient's record shall furnish documentation of observations of the patient's behavior, ordered and supervised treatment, and responses to treatment.
>
> "12.1.7. The patient's record shall provide information for the review, study, and evaluation of the treatment provided to the patient."

JCAH documentation requirements are not limited to psychotherapy. The JCAH Accreditation Manual for Hospitals (1982 edition) provides under medical records services that:

> "An adequate medical record shall be maintained for every individual who is evaluated or treated as an inpatient, ambulatory care patients, or emergency patient, or who receive patient services in the hospital administered home care program.
>
> "The purposes of the medical record are:
>
> * * *
>
> "to furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay."

Having noted the CHAMPUS requirements, especially the JCAH standards, for case specific information, a summary of the information furnished in this appeal case is necessary. The case documentation furnished by the appealing parties includes: a hospital admission summary; an initial treatment plan; a treatment plan/transfer note; two updated treatment plans; 14 staff summaries (progress and planning notes); daily progress notes from the hospital staff; physician orders; school evaluation and assessment reports; test results and summaries from the initial 30-day admission; and a discharge summary. In addition, there exists the professional provider and institution billings, correspondence from Dr. Novello on behalf of the Psychiatric Institute, and correspondence from one of the physicians with the professional providers, Dr. Bates. The inadequacy of case specific information for the entire 7 month inpatient confinement and related care can be demonstrated through individual review of the four treatment plans and the 14 staff summaries.

- Treatment Plans

The following four treatment plans were submitted by the "treating psychiatrists." Though Dr. Bates is listed as the admitting psychiatrist, Dr. Stone saw the patient during the first 30 days of her admission and Dr. Bates, apparently, had no contact with the beneficiary until November 5, 1981.

1. Treatment plan dated October 15, 1981, and signed by Nancy W. Stone, M.D., attending psychiatrist. The reason for the hospitalization is stated to be "a failure of outpatient therapy to reverse the patient's symptoms sufficiently to enable her to return to school." The current objectives/expected dates of achievement indicate:

> "First objective is a comprehensive diagnostic evaluation which will include psychological testing. A second objective is to support the patient's mother to assist her to resist the patient's efforts to force her family to withdraw her from treatment. A third objective is to provide assistance to the patient in area of relationships with peers in the unit. A fourth objective is to determine whether the patient can turn to therapy in an outpatient setting following the evaluation period or whether it will be necessary for her to continue for a longer period of therapy in the hospital."

Under "psychotherapy" it is stated, in this treatment plan, that, "the patient is receiving individual therapy at weekly intervals, family therapy each week, and group therapy five times a week." However, Dr. Stone billed for five individual sessions per week.

The admitting diagnosis was: "axis I 309.21 separation anxiety disorder; axis II 301.50 histrionic personality disorder; and axis III possible tension. The treatment plan noted the expected length of hospitalization "will be determined when all diagnostic studies have been completed."

2. On November 4, 1981, Dr. Stone prepared a "treatment plan/transfer note." The treatment plan reiterated the four objectives noted in the October 15, 1981, treatment plan, including the fourth objective which was "to determine whether the patient could return to therapy in an outpatient setting following the evaluation period." Dr. Stone concluded, "It was felt that these objectives were achieved, and a decision was reached by the staff, the patient, and her family that it would be best for the patient to continue therapy for a time in the hospital." Under psychotherapy it is stated, "The patient has made good use of beginning therapy in all modalities." The number and type of psychotherapy sessions was not noted. The expected length of hospitalization is stated to be "brief to intermediate." Under discharge criteria it was stated,

"sufficient changes in the patient's functioning and in family dynamics to support the patient's return to school. . . ."

What "would be best for the patient" is a laudable and desirable goal. However, in determining whether CHAMPUS cost-sharing is appropriate, the care must be medially necessary and not above the appropriate level. The treatment plan/transfer note did not specify the services necessary to meet the patient's needs (standard 18.1.7.); the services, activities and programs planned (standard 18.1.11.); staff members assigned (standard 18.1.11.); or frequency of treatment procedures (standard 18.1.12.). There was a generalized discharge criteria - able to return to school. Specific goals (standard 18.1.9.) and specific objectives that relate to the goals written in measurable terms and expected achievement dates (standard 18.1.10.) were not given.

In essence, this treatment plan/transfer note is the basis for keeping the beneficiary as an inpatient. It totally fails to address how the beneficiary was doing in school. Yet it was the beneficiary's failure to attend school that was given as the reason for her being an inpatient. It failed to discuss the fourth objective, "To determine whether the patient could return to therapy in an outpatient setting following the evaluation period." It also failed to mention that Dr. Stone would no longer be the beneficiary's therapist and that Dr. Bates would thereafter be the beneficiary's therapist.

3. The third treatment plan is dated January 31, 1982, and was signed by Dr. Bates. The January 31 treatment plan under progress stated that the beneficiary "was transferred to the Open Adolescent Unit on November 4, 1981, after an initial evaluation by Dr. Nancy Stone and her team on the Adolescent Unit." Under psychotherapy it noted:

> "[The beneficiary] has been involved in individual psychotherapy with Dr. Bates on a twice a week basis . . . [the beneficiary] is involved in daily group psychotherapy led by Clark Bates, M.D. and Eileen Ivey, ACSW . . . [the beneficiary] is seen with her family in conjoint family therapy with Eileen Ivey on a weekly basis."

However, Dr. Bates billed for five individual therapy sessions per week.

The expected length of hospitalization was stated to be "two to three more months." The November 4, 1981, treatment plan/transfer note stated the expected hospitalization was "brief to intermittent." Dr. Bates' January 31, 1982, updated treatment plan gave no explanation for an additional 2 to 3-month inpatient stay following the initial 4 months of inpatient care. Dr. Bates failed to detail specific goals (standard 18.1.9.), specific objectives that relate to the goals in measurable terms and

expected achievement dates (standard 18.1.10.), and failed to delineate specific criteria for discharge (standard 18.1.13.). No discharge criteria were given.

Dr. Bates stated that, "the failure of outpatient therapy to reverse the patient's symptoms sufficiently to enable her to attend school was the major reason for hospitalization." Dr. Bates mentioned the beneficiary's school progress in two sentences. He first stated "she has made fairly consistent progress in her behavior at school. . . ." Second, under "current objective" he stated, "First objective is to continue to support [the beneficiary] in developing satisfactory school performance."

4. The fourth treatment plan, which is dated April 21, 1982, was signed by Dr. Bates. It states, "Since the last treatment plan, dated January 31, 1982, [the beneficiary] has made a great deal of progress. Although her oppositional behavior continued for a long period of time, recently, she has begun to accept her parent's [sic] authority and she has a gained a great deal of mastery over her aggressive impulses, particularly directed towards family members." Under psychotherapy, it states:

> "[The beneficiary] continues to participate in twice a week individual psychotherapy with Dr. Bates. . . . [The beneficiary] also participates in daily group psychotherapy which has tended not to be a useful vehicle for change recently. . . . [The beneficiary] and her family participate in weekly family psychotherapy with Rich Chvotkin, ACSW, and lately this has been a most valuable form of treatment. . . ."

The diagnosis is given as, Axis I: 309.21 separation anxiety disorder and 303.81 oppositional disorder and Axis II: 301.50 histrionic personality disorder. The expected length of hospitalization is given as "one to two months." Two and a half weeks later on May 7, 1982, she was discharged. In the staff notes for May 7, 1982, Dr. Bates made the following entry:

> ". . . she is discharged today, with maximum hospital benefits, status improved."

Staff Summaries

The file also contains 14 "progress and planning notes." They are "standard" forms, apparently developed by one of the providers, and include the following statement: "Instruction: must be completed by the physician and updated every 2 weeks unless notified otherwise (i.e., Medicare, CHAMPUS, etc.)."

The progress and planning note for October 21, 1981, include Dr. Stone and Syd Brown, Ph.D., clinical psychologist, as

attendees. Both signed the progress and planning note. The comments under "clinical progress" refer to therapy sessions but do not indicate the type of therapy sessions, who conducted the sessions, or how frequently or when they were held. The progress and planning note includes the following heading:

> "11. Current Treatment Progress: (Note significant changes from Treatment Plan including A) Physician's services, B) Diagnostic Testing and Results, C) Medications, D) adjunctive therapy, E) other services, i.e., school nursing, family therapy, etc.)"

No entries were made under "Current Treatment Program" in this or any of the subsequent progress and planning notes.

The October 28, 1981, progress and planning note included Drs. Stone and Brown as attendees. This note indicates that an agreement was reached to continue the hospitalization for a longer time before the beneficiary could return home. The progress note was signed by Dr. Stone; it also includes Dr. Brown's typed name, though unsigned by him. No entries were made under "what is need for continued hospitalization" or under "current treatment program."

In reviewing the medical documentation, it must be kept in mind that much of it was prepared during the 30-day diagnostic admission and just prior to and at discharge. The documentation by Dr. Bates from November 5, 1981, when Dr. Bates first began to see the beneficiary, through the end of March 1982 is particularly scanty. In November, Dr. Bates prepared one "progress note." In December, he prepared one progress note. In January, there were two progress notes and one updated treatment plan. In February, there was one progress note by Dr. Bates. Therefore, in the 4-month period from November 1981 through February 1982, Dr. Bates prepared a total of five progress notes and one updated treatment plan. In March there were four progress notes and in April there were three progress notes and an updated treatment plan. Possibly the initial denial of CHAMPUS cost-sharing by the fiscal intermediary issued on February 24, 1982, spurred the increase in the frequency of progress notes for March and April.

The JCAH Manual in standard 18.3.2. provides:

> "In inpatient . . . facilities, the master treatment plan shall be reviewed and updated as frequently as clinically indicated . . . and every 60 days thereafter for the first year of treatment."

Dr. Bates should have updated the treatment plan at least on January 4, 1982, March 4, 1982, and May 4, 1982.

The November 13, 1981, progress and planning note included Dr. Bates and Ms. Ivey as attendees and was signed by Dr. Bates. The note has a reference to therapy but does not state how frequently or when the sessions were held. This progress note failed to document all treatment rendered to the patient (standard 18.2.b.) and failed to give a description of the response of the patient to treatment and the outcome of treatment (standard 18.2.e.). The note fails to comply with the requirement that entries involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed (standard 18.2.2.).

The December 10, 1981, progress note does not indicate when therapy was conducted or who conducted the therapy, though there was a reference to weekly family therapy sessions. The note did contain some detailing of the beneficiary's conduct during family therapy sessions. This one page progress note, however, did not document implementation of the treatment plan (standard 18.2.a.); it did not document all treatment rendered to the patient (18.2.b.); there was not chronological documentation of the patient's clinical course (standard 18.2.e.); and there was no description of the actual behavior observed in group and/or individual therapy (18.2.3.).

The remaining progress notes follow the same pattern with the same deficiencies as described in the above progress and planning notes.

The January 4, 1982, progress note which was signed by Dr. Bates, indicates the beneficiary and her family met with Ilene Ivey, ASCW, on a weekly basis. There is a reference to group therapy, but it does not indicate who conducted the therapy or when it was conducted. Under the "need for continued hospitalization," it is stated:

> "[The beneficiary] has recently begun to talk more openly about her previous depression, her view of herself as a 'bad person' and previous suicidal plans. At this time, she needs the structure and safety of the inpatient unit in order to monitor the potential return of these thoughts and actions."

The January 13, 1982, note was also signed by Dr. Bates. It referred to the family therapy meetings with Ms. Ivey; however, there is no specific reference to group or individual therapy. The need for continued hospitalization is stated to be:

> "[The beneficiary] continues to require the structure and safety of inpatient setting while beginning to understand her need for symptom development earlier relating to school refusal and her need to control her environment. Although she has made some

> progress, her gains need to be consolidated while she continues to need to gain mastery over her impulses, especially those of an aggressive nature."

The progress note for February 16, 1982, by Dr. Bates stated that "[the beneficiary] continues to need the structure and security of the inpatient setting in order to deal with her school refusal syndrome."

The March 4, 1982, progress and planning note stated:

> "[The beneficiary's] picture of difficulty with authoritative figures, angry outbursts at times, and refusal to obey limits and rules warrants additional diagnosis of oppositional disorder. She continues to need the structure and safety of the inpatient setting in which to deal with her anger at authority figures which seems to consistently get her into trouble. Estimated length of stay is two to three months."

This note also stated an "evaluation meeting was held with [the beneficiary] and her parents and Eileen Ivey, ACSW, and Dr. Bates." In the meeting both parents indicated that, "[the beneficiary] has not changed her 'attitude' towards them at this time." It was also stated in the progress notes that family meetings continued on a weekly basis and that the beneficiary participated in group therapy on a daily basis. The daily notes by hospital staff show the family counselor, Ms. Ivey, left in early March. The staff notes for March 3 state the beneficiary "did a good job in terminating" with the counselor. This change in family therapists is not noted by Dr. Bates in his progress notes or treatment plans.

The unsigned March 11, 1982, progress note, apparently prepared by Dr. Bates, continued to refer to group and individual therapy. It was similar to the other notes.

The March 18, 1982, progress and planning note by Dr. Bates stated, "[The beneficiary] continues to need the structure and safety of the inpatient setting in which to deal with her anger at authoritative figures and family members at this time."

The March 25, 1982, progress and planning note by Dr. Bates gave no reason for continuing the hospitalization. It did state the beneficiary "made little use of group psychotherapy as a vehicle for self-expression. In individual therapy she has talked about 'working her problems out alone'. . . ."

The April 2, 1982, progress note by Dr. Bates indicated, "It appears that [the beneficiary] is making some progress in beginning to contain her anger and her parents are beginning to

make some progress in the gaining of authority over her in the family system."

The April 9, 1982, progress note by Dr. Bates states, "In general she seems to be more able to contain her anger and there is less of a tendency to act out her aggressions. She is beginning to talk about her future and at this time she is talking about going home and working out her problems." There is no indication of the need for continuing hospitalization or for how long.

The April 16, 1982, progress note by Dr. Bates stated, "[The beneficiary] is beginning to talk about discharge and the family is considering various options for school placements." The type and frequency of therapy is not noted. This was the last progress and planning note.

On May 7, 1982, the beneficiary was discharged. Dr. Bates' discharge summary stated, "The patient was referred by Dr. Gemmeli of the Bethesda Naval Hospital." In discussing "problem 1: refusal to attend school," Dr. Bates indicated that, "On the date of admission, the recommendation was made that either the patient return to school and continue in outpatient therapy or that she be hospitalized for an evaluation. [The beneficiary] said she could not go back to school and was thus brought to the hospital." The discharge summary also stated under mental status at admission "no suicidal or homicidal ideas were reported." Under progress, it was reported:

> "[The beneficiary] initially was quite surprised that her family had decided to leave her at the hospital in spite of her protests. She then talked of going AWOL and when her peers confronted her with the fact that she would only be brought back to the hospital if she did, she assured them that this would not be the case. She indicated that she has always won in disagreements with her family. She talked about how wonderful her life had been in Hawaii and how peers in this area cannot understand because they are not military families and they have never been to Hawaii. Evaluation of [the beneficiary] in the Developmental School setting suggested that she may have suffered from a test phobia for some time. [The beneficiary] and her parents participated in various treatment approaches to help her with her problems. Her family consistently participated in family therapy. [The beneficiary] began to attend school and made a great deal of progress in the school setting. However, her oppositional behavior continued for quite a long period of time and with numerous breakings of rules, plans to go

> AWOL, and threats to 'get back at people' if they didn't let her get her way. Temper tantrums often developed in family meetings when [the beneficiary's] parents refused to let her have her way or brought up material that [the beneficiary] did not want to talk about; [the beneficiary] would often storm out of a family meeting. Gradually, over the course of the hospitalization, [the beneficiary] became somewhat more in control of her anger and her fantasies of omnipotence began to diminish. Although this took a great deal of time, even around the point of discharge, [the beneficiary] continued to be histrionic and in control of other people. Arrangements were made for [the beneficiary] to return home and to see a home-bound teacher for the remaining part of the school year."

Her condition was stated to be "improved." For "after care plans," it was stated that:

> "[The beneficiary] had hoped to attend the Developmental School on an outpatient basis but this was not possible due to limitation in openings for new youngsters. Consequently, arrangements were made for [the beneficiary] to return home and see a home-bound teacher on a three times a week basis for the remainder of the school year . . . Follow up outpatient therapy was arranged with Dr. Bates on a twice a week basis initially."

Except for one medical reviewer who concluded that the information furnished to him was so inadequate as to prevent forming an opinion regarding the beneficiary's hospital admission, all medical reviewers of the case opined that a diagnostic admission of 30 days was warranted. I agree. The hospital admission summary, the initial treatment plan, and the test results and summaries from the initial 30-day admission adequately support a hospital claim for diagnostic inpatient care of the beneficiary from October 5, 1981, through November 4, 1981, as well as claims for the related professional provider services of Dr. Brown (psychological testing) and Dr. Rickler (neurology consultation).

I find, however, that claims for hospitalization of the beneficiary from November 5, 1981, to May 7, 1982, and the related professional provider services of inpatient psychotherapy are not sufficiently supported by medical documentation or information required under CHAMPUS. As noted above, in the review of the various treatment plans and staff summaries, specific JCAH medical records standards were not complied with,

resulting in inadequate case specific information. In addition, although the "documentation" appears to be voluminous, there are no notes or records detailing or describing a single group or individual therapy session. As noted by the Hearing Officer, "On the issue of documentation of individual psychotherapy sessions by Dr. Bates, neither Dr. Novello nor Dr. Bates could supply any ongoing assessments of the mental status of the patient nor any reports of individual psychotherapy sessions."

In the absence of case specific information meeting the CHAMPUS minimal requirements for medical documentation, I find that the appealing parties have failed to establish by substantial evidence entitlement under law and regulation CHAMPUS cost-sharing of the medical care in dispute. Therefore, I find that the claims for hospitalization of the beneficiary from November 5, 1981, to May 7, 1982, and the related professional services of inpatient psychotherapy from October 5, 1981, to May 7, 1982, must be denied CHAMPUS cost-sharing for lack of adequate medical records in support of the claims for medical care.

Medically/Psychologically Necessary Care and Appropriate Level of Care

Under the Department of Defense Regulation 6010.8-R, chapter IV, B.1.g., CHAMPUS benefits may be extended for institutional care only at the appropriate level required to provide the medically necessary treatment.

Medically necessary is defined in DoD 6010.8-R, 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, . . ."

The CHAMPUS regulation, DoD 6010.8-R, chapter IV, G.3., specifically excludes from CHAMPUS coverage:

> "Institutional Level of Care. Services and supplies related to inpatient stays in hospitals and other authorized institutions above the appropriate level required to provide necessary medical care."

The primary reason given for the beneficiary being hospitalized in this case was her refusal to attend school. The available records do not document the beneficiary was a physical threat to others or to herself. The admission evaluation by Dr. Stone states, "No suicidal or homicidal ideas were reported." Dr. Brown's psychological evaluation stated, "While the likelihood of her directly attempting suicide is low, her poor judgment could result in a situation becoming out of her control and she might be hurt as a consequence of that."

The staff at the Developmental School that the beneficiary attended while at the Psychiatric Institute provided the following assessment of progress for the beneficiary for the period from October 5, 1981, to November 11, 1981:

> "[The beneficiary] has been enrolled in the Developmental School for six weeks. The small group setting, individualized education plan, and opportunity for frequent teacher support and redirection have enabled her to achieve success in each of her classes.
>
> "She has demonstrated her ability to stay on task and to ignore disruptive behavior. She is motivated to do well, asking for and accepting help appropriately. Her work is neat and accurately completed. She does best on structured material; concept application and generalization are difficult for her. Concurrently, her organization skills are not as well developed as would be expected. [The beneficiary] does not like to take risks, so she is reluctant to contribute her opinions in a group discussion.
>
> "[The beneficiary] will need the continued support of a special education program in order to maintain the progress she has made thus far as well as to strengthen: 1) her self-image, 2) her peer relationships, 3) her positive leadership skills, and 4) her ability to work on abstract materials."

She was not absent at all during the report period and was given the following grades:

	SUBJECT	QUARTER GRADE
1.	English 8	B+
2.	Math 8	B-
3.	Career Education	A-
4.	World Cultures	B+
5.	Physical Education	A-

Clearly the beneficiary was a disturbed adolescent and some therapy was medically necessary. It is undisputed that the beneficiary required a structured school environment; the need for an inpatient setting in an acute care psychiatric facility, however, is disputed.

The initial peer review requested by the CHAMPUS Fiscal Intermediary involved only the claims for the 88-day inpatient period from October 5, 1981, to December 31, 1981. Dr. Johnson, one of the reviewers, gave a short, conclusory opinion that the "care <u>appears</u> to have been medically necessary." (Emphasis

added). He went on to state 88 days was the upper limit of inpatient care that was necessary and that a "severe" separation anxiety disorder and histrionic personality disorder would require hospitalization. Dr. Johnson was the only medical reviewer to recommend that more than 30 days inpatient care be allowed. It appears he did not want to recommend retroactively denying the CHAMPUS claim. The fiscal intermediary was of the same opinion as evidenced by its rationale in subsequently allowing CHAMPUS cost-sharing of hospitalization until March 25, 1982, due to the lengthy peer review process.

Dr. Noah, also one of the three reviewers for the fiscal intermediary, opined a 30-day diagnostic admission was justified. He considered the 88-day period that he was reviewing to be excessive.

The third reviewer for the fiscal intermediary, Dr. Coleman, found the information provided so lacking that he could not form a medical opinion of the medical necessity and appropriateness of the beneficiary's hospitalization.

Prior to issuing its formal decision, OCHAMPUS had the entire episode of care reviewed through the American Psychiatric Association by Dr. Margolis. In his opinion, Dr. Margolis "challenged" the need for the entire hospitalization. He noted only three or four outpatient therapy sessions were conducted before the admission, and no attempt was made to explore alternatives to the inpatient setting in an acute care facility.

Dr. Margolis further noted "there were no [emphasis in original] ongoing assessments of the mental status or reports of individual psychotherapy sessions." He concluded the level of care "seemed more like [a residential treatment center] rather than acute hospital." He further opined:

> ". . . the usual standard [norm for medical practice in the United States] would have been to try outpatient, special education or partial hospitalization first. If admitted, the usual treatment would have been for 2-4 weeks and then a trial back home with day treatment (partial) or outpatient and special education." (Emphasis in original.)

CHAMPUS is an at risk program, with some limited exceptions for preauthorization of care which are not applicable to this appeal. As an at risk program, claims for CHAMPUS cost-sharing are processed and reviewed after the medical care has been received. The claims are adjudicated based on applicable law, regulation, and the specific facts - including medical documentation of the treatment.

Aside from one reviewer, all other reviewers who gave opinions found only the first 30 days of the inpatient setting were medically necessary. There is insufficient medical evidence

in the record to justify as medically necessary the inpatient acute hospital setting after the first 30 days. To the contrary, the medical evidence supports a determination that after the first 30 days, a residential treatment center would have been the appropriate level of care for the beneficiary.

I concur with Dr. Margolis' medical opinion. Nothing provided by the Psychiatric Institute or Dr. Bates rebuts Dr. Margolis' opinion. I find, therefore, that the medical/psychological necessity of the beneficiary's inpatient care after November 4, 1981, is not adequately supported by the medical information in the record. In addition, the record fails to establish the appropriateness of the acute inpatient care after November 4, 1981.

It appears the Hearing Officer's recommendation to allow CHAMPUS cost-sharing of hospitalization from October 5, 1982, to March 25, 1983, was primarily based on the opinion of the OCHAMPUS Medical Director, who is a child psychiatrist. His opinion (which was transcribed from an oral conference) is quoted in its entirety:

> "Question: Is the care provided from October 5, 1981, to May 7, 1982, the appropriate level of care required to provide medically necessary care?
>
> "Dr. Rodriguez:
>
> "I have reviewed the peer review conducted in this case. Not only the reviews prior to the FI determination in 1982, but specifically the peer review opinions in February, 1982 by Drs. Johnson, Colman and Novak. These reviewers independently reached conclusions that the inpatient level of care was marginally documented in terms of its justification and did raise some question about medical necessity of a lengthy inpatient hospital stay for this beneficiary, raising in their questions, the level of disability that she experienced, that would have required the inpatient care for active treatment. Specifically each of these reviewers has raised some question about the appropriateness of outpatient level of care beyond the 30 to 88 days that were considered medically necessary. Subsequently, a review on an appeal level of Dr. James Margolis, dated February 28, 1983, reviewed all of these records, that is the clinical medical records, plus the peer review reports.
>
> "Dr. Margolis raises, again, a number of concerns, but has several statements in here

which allow for some range of interpretation about the length of inpatient hospitalization. He states as a general principle, 30 days would have been adequate to provide an inpatient evaluation that would have been allowed a more appropriate level on a partial hospital level of care or some outpatient, more intensive outpatient level of care to have been provided, such as 'alternate school program partial hospitalization or intensive family therapy.'

"However, he then goes on to say that as early as early January, because the beneficiary was having regular home passes and that the record did not seem to indicate a significant amount of dysfunction in the ward unit and that she appeared to be progressing and that there were no significant considerations to require inpatient level of care.

"Finally, he goes on to say there is no justification, by the record, and he states it as saying the care beyond mid-March would have been highly liberal or, I think his term was something in the nature of quite liberal or something of that effect.

"But, in general, what he says here is that, certainly the original review, authorizing care to March the 25th was generous; by this time she and her family had worked out most of their conflicts. The statements by [the sponsor], and by Dr. Novello, the supervising 'ward chief' would not change the contention that care beyond the 25th of March under no circumstances can be justified. It should raise some note that several reviewers have independently raised questions about the appropriateness of this lengthy hospital stay. This will not be a problem in the future because this beneficiary would not have been able to have been allowed care beyond sixty days under any circumstances and care would have had to proceed on an outpatient basis after that. Under these circumstances, given the statements by the provider, by the sponsor and by the peer reviewers, I would say that care up until March the 25th, stretched very liberally and judiciously should be authorized, but under no circumstances would care beyond the 25th of March be considered medically necessary. That in and of itself is an arbitrary date

and I would consider it arbitrarily longer than what the record would otherwise justify but I am making that determination based upon the peer reviewers' generous estimation of care based on some inferences drawn from the record that there might have been some continuing need for some therapeutic issues to be worked out during the latter phases of her hospitalization. Under no circumstances can the care from the 25th of March through the 7th of May be considered medically necessary. It is simply not justified from the record.

"Question:

"There is a statement in this APA peer review from Dr. Margolis, 'However, I challenge the need for the entire hospitalization, especially after an initial evaluation of one month.' What is your opinion of this statement?

"Dr. Rodriguez:

"He is talking about a general principle as much as he is talking about this specific case. I am referring to the entire case record which is a balance of each of the peer reviewers' recommendations, plus his observations. He also makes a statement in there about mid-March, in effect finding no justification beyond mid-March. So, I am upholding that, plus adding ten days, which would be consistent again, with at least one of the reviews by one of the peer reviewers. The other peer reviewers by the way tended to be much more conservative in their estimation of the length of hospitalization being required. There are some serious concerns raised in this question.

"I think that there are questions that should be raised in the record:

"Number one; that the treating psychotherapist under no circumstances actually treated this beneficiary more than twice a month. I consider that inexcusable and not in keeping with standards of care generally provided in the U.S. The great bulk of the care was in fact indicated by the record to have been provided by non-psychiatric mental health professionals and mental health specialists who are not

mental health professionals and that, in fact, Dr. Margolis is quite correct, that this treatment unit, rather than reflecting the usual mix of professional services at an acute inpatient level of care, in fact, represents more of a residential treatment center level of care from the staffing point of view and the intensity of professional services. It is just this sort of reason that Congress put a cap on acute inpatient psychiatric care because they considered this kind of care to be an abuse. Secondly, I seriously question what is Dr. Novello's role as 'supervisor' of Dr. Bates who is described as being an independent provider of mental health services working for the Metropolitan Psychiatric Group.

"Is Dr. Bates in need of supervision? Is he a resident at the time of the care? Is he a qualified independent provider of mental health services? In fact, what was he actually doing? Was he himself, actively managing the care; the record does not seem to reflect it. The record also does not have any notations made by Dr. Novello that indicates his supervision. If Dr. Novello in fact was literally supervising this man, then I raise questions about Dr. Bates' qualifications which further underscores the comments made by the peer reviewers; that this shows a low level of medical involvement in this case. This should raise some questions about the appropriateness for the length of time involved, the appropriateness of this hospitalization.

"Again, I am being most generous to use Dr. Margolis' term in saying that I would consider by stretching my imagination and the record, the care up till March the 25th could in some kind of construction, be justified. But nobody can justify this beyond the 25th of March and I do not think Dr. Novello has any justification for saying so; his statement does not in any way verify the record.

"Question:

"Do you believe the patient should have been treated in a residential treatment center or do you believe any of this hospitalization is documented as being the appropriate level of care?

"Dr. Rodriguez:

"Personally, I think, and this is what Dr. Margolis was trying to say, that if there was need for a diagnostic hospitalization and evaluation, perhaps up to 30 days for an acute inpatient level of care could be justified and after that, transfer to an RTC should have occurred. That has never been any kind of formal process by which that could be required in the future. That is now being required de novo by virtue of the fact that we are capping psychiatric care; and in the future, if a beneficiary like this were hospitalized and after 60 days it was determined that she need care beyond the 60 days and they were willing to submit that to peer review then they could have transferred her to an RTC and the continuation of care in the RTC would have been subjected to periodic peer review.

"Question:

"Does this care appear documented as being the appropriate level of care, after 30 days of evaluation through to March?

"Dr. Rodriguez:

"Again, I would say given the lack of definition of just what is required for RTC versus acute inpatient level of care by this program or any other established body of legislation in this country, such as the National Institute of Mental Health, that we are forced, in effect to acknowledge that this level of care was justified even though in retrospect it might more have been appropriate for an RTC. So I do not think that we would be able to justify in a hearing that this care should have been provided in an RTC, and it was just that issue that caused Congress to say that if you cannot monitor, if you cannot in effect define more clearly just where the RTC level of care begins and the acute inpatient level of care begins, then we will help you with that CHAMPUS by capping the care and we will close down units such as this, or we will force them to come in and get an RTC provider number, which is what they are.

"So, what I am saying is let's dispense with this case, let's be judiciously liberal and

> generous, as much as we can, but at the point where it clearly cannot be justified any farther we have to draw the line and the line is on the 25th of March. And again, I am acknowledging that is arbitrary, just like to say that the 7th of May is when she needed to be discharged; I think that was an arbitrary discharge date, it is not justified by the record. We at least justify our contention on the record, in fact, if we were to be very harsh about this, to use Dr. Novello's term, we could on the basis of the record say that care beyond 30 days is not justified; care beyond 88 days is not justified. We chose again, to take into consideration the concerns of the peer reviewers, the concerns expressed by the sponsor and the provider and to give broad allowances for the very poor record and apparently limited documentation provided justifying this care.
>
> "I think that what we said was that what we took into consideration was that two out of three reviewers said thirty days. I've taken that into consideration by the way I have signed off on Dr. Margolis' statement as well.
>
> "What we did not have available at the time of the earlier review, was [the sponsor's] statements, Dr. Novello's statement and the entire medical record. In effect what we had was the clinical records that were reviewed by Dr. Margolis. So, I am making this determination on the basis of all the records involved."

I read Dr. Rodriguez's statement as being consistent with my finding that the records do not support the medical necessity and the appropriateness of the inpatient setting in an acute care hospital after the initial 30-day diagnostic admission. Dr. Rodriguez stated that in view of the new statutory limitation on inpatient psychotherapy of 60 days effective January 1, 1983, (enacted December 21, 1982, in the Department of Defense Appropriation Act of 1983, Public Law 97-377, 96 Stat. 1830 and since enacted into permanent legislation at 10 U.S.C. 1079(a)(6)) this situation would not likely occur in the future. He recommended we dispense with the case and be liberal and generous.

I am constrained in the expenditure of appropriated funds to follow applicable law and regulation. The OCHAMPUS Medical Director is correct in his statement that there is no CHAMPUS policy or requirement that beneficiaries transfer from an acute care psychiatric hospital to an RTC; however, if an RTC is the

appropriate level of care, then CHAMPUS is prohibited by law and regulation from cost-sharing a higher level of care. The OCHAMPUS Medical Director's recommendation to cost-share care from October 5, 1981, to March 25, 1982, is not supported by law and regulation; nor is the Hearing Officer's Recommended Decision, supported by law and regulation. Therefore, this portion of the Hearing Officer's Recommended Decision is rejected.

I find that the inpatient care from October 5, 1981, through November 4, 1981, was medically necessary for diagnostic testing. Therefore, CHAMPUS cost-sharing of the first 30 days of inpatient care is authorized.

I further find that the beneficiary's inpatient setting was not medically necessary nor the appropriate level of care from November 5, 1981, to May 7, 1982. The beneficiary's mental health care after November 4, 1981, could have been provided in a lower level of care facility than the acute inpatient facility. The beneficiary did not require the type, level, and intensity of service that could be provided only in an acute inpatient hospital setting. As previously noted, the Regulation excludes "services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care." Consistent with this regulation provision and prior FINAL DECISIONS (e.g., OASD(HA) Case File 83-51) the institutional billing and all other related care, such as the therapy billings, are denied CHAMPUS cost-sharing from November 5, 1981, to May 7, 1982.

Inpatient Psychotherapy

The claims history for professional services related to the inpatient care in this case is inconsistent with the CHAMPUS claims submitted. Testimony at the hearing and correspondence from Dr. Bates indicate that the beneficiary received daily group therapy 6 days a week, two individual therapy sessions per week, and a family session once a week. It was indicated that five individual therapy sessions per week were billed, however, since that was the maximum number of individual therapy sessions allowed by CHAMPUS.

With the exception of a charge for psychological testing and for a neurological consultation, the monthly billing submitted by the Metropolitan Psychiatric Group (formerly Professional Associates) described the services as "inpatient psychiatric care 50M" with a procedure code of 90805. Procedure code 90805 represents individual psychotherapy; more specifically, psychotherapy, verbal, 50 minutes. From October 5, 1981, to November 3, 1981, 22 individual therapy sessions by Dr. Stone at $65.00 per session were billed for the beneficiary's inpatient psychiatric care. From November 5, 1981, to May 7, 1982, Dr. Bates billed 126 sessions; the first 35 were billed at $65.00, the last 91 at $70.00. In addition, there were two sessions on April 27, 1982, and April 30, 1982, by Dr. Hershberg

billed at $70.00 each; and there was one session by Dr. Fischman on November 30, 1981, billed at $65.00. The claims for all of these services also cited procedure code 90805. The psychological testing by Dr. Brown and the neurology consultation services by Dr. Rickler during the initial 30 days of hospitalization were also billed through the Metropolitan Psychiatric Group.

A billing statement is not, and never has been, adequate documentation to substantiate a CHAMPUS claim. Claims generally are paid on the basis of a billing statement; however, if a question exists concerning the medical necessity of treatment or the appropriate level of treatment, documentation beyond a billing statement is required. In general, the applicable JCAH standards must be complied with, and the appealing party has the burden of supporting claims with adequate records.

Questions involving required documentation have been addressed in prior Final Decisions. In OASD(HA) Case File 83-50, which also involved inpatient therapy provided by a psychiatrist, it was stated, "Generally accepted medical practice requires periodic progress notes be recorded by a provider detailing the care rendered and the dates of care rendered." The decision, went on to state:

> "I must emphasize to the appealing party that CHAMPUS does not disbelieve the psychiatrist or her. The issue herein encompasses not only if and when the services were performed but also whether the claimed services were the kind of services required by this beneficiary."

Documentation is needed to determine if the care provided was medically necessary. FINAL DECISION OASD(HA) Case File 83-10 addressed the documentation needed to perfect a CHAMPUS claim. OASD(HA) Case File 83-10 involved inpatient psychotherapy by both a psychiatrist and a psychologist. It was held that:

> "It is usual and customary for therapists to record notes of their sessions with patients. In the absence of such notes or other appropriate documentation, it is difficult to determine that services were actually performed or that the services were appropriate and medically necessary in the treatment of the patient.
>
> "CHAMPUS will cost-share only those medically necessary services which are appropriately and adequately documented."

The FINAL DECISION in OASD(HA) Case File 83-27 specifically addressed, as a primary issue, whether sufficient documentation was provided to determine if the psychotherapy sessions provided the beneficiary were medically/psychologically necessary and appropriate medical care for coverage under CHAMPVA. [CHAMPVA beneficiaries are entitled to medical care subject to the same or similar limitations as medical benefits furnished to certain CHAMPUS beneficiaries.] OASD(HA) Case File 83-27 involved outpatient psychotherapy, and the treating physician's office notes were illegible. The decision held:

> ". . . I find insufficient evidence to support a finding of medical necessity for any of the psychoanalytic therapy. This finding does not imply that the therapy was not required by the patient, only that the provider has failed to document adequately the case, his choice of treatment, the treatment plan, and the case summary. In the absence of adequate documentation to support the medical/psychological necessity of the therapy, CHAMPVA coverage cannot be authorized."

In the appeal case currently under consideration, Dr. Bates in a letter dated July 25, 1983, addressed to the OCHAMPUS Chief, Appeals and Hearings, stated:

> "During the entire period in question [the beneficiary] was enrolled in an intensive psychotherapy program. I saw her at least twice per week for individual therapy sessions of one hour duration and I saw her for daily group psychotherapy, six times per week. In addition, there were frequent brief individual meetings which are noted on the billing statements as routine hospital visits. This is the typical pattern of our intensive inpatient treatment. The medical record does not contain a notation based on each specific contact I had with the patient. Such is not the practice at our psychiatric hospital.
>
> "While I do understand that in some medical surgical hospitals it is customary for the physician to place a brief handwritten note on the chart each time he sees the patient, this is simply not the style of documentation at The Psychiatric Institute. Hence, I feel that the Peer reviewer for the American Psychiatric Association who concluded that a hospitalized patient was seen 'no more frequently than two times per month' is grossly misstating the case. I take strong

> exception to your denial of the many hours of work that I did with this patient.
>
> "I am attaching a copy of the charges submitted during the patient's hospitalization. They are an accurate record of my contacts with the patient. Since I had never been notified by CHAMPUS that I must place a daily note on the chart and since I have treated a number of CHAMPUS patients in the past based on my current method of record keeping, I feel that I should not be held to a new and arbitrary record-keeping system. I ask that the billing statement be accepted as a definitive record of my work with the patient and that I be reimbursed accordingly."

The "new and arbitrary record-keeping" system that Dr. Bates is apparently referring to is the requirements and standards for his profession. Standards in effect since, at least, the 1979 JCAH Manual. It is also clear that, if his letter is accepted at face value, he was unaware of the JCAH records standards. The JCAH does not consider its records standards minor technicalities or something to be left to the "style of documentation" of the provider. For example in Manual/83, the introductory section entitled, "Using the Standards," provides:

> "Although all standards have an impact on accreditation decisions, certain chapters and certain standards within chapters must clearly reflect the quality of patient care and are therefore highlighted in the accreditation decision process. These chapters and standards within chapters pertain to, but are not necessarily limited to, the following:
>
> "o Patient management issues including intake, assessment, treatment planning, progress notes, discharge summaries, and special treatment procedures. . . ." (Emphasis added.)

The courts have taken note of JCAH requirements. In Woe v. Cuomo, 559 F.Supp. 1158 (E.D. New York 1983), a case which involved a class action involving a question of due process over care at state mental hospitals, the court favorably noted:

> "By its own description, the JCAH 'provides a professionally recognized benchmark by which a facility may expect to be measured in its pursuit of excellence.' . . . Its criteria are designed to exceed minimally adequate standards . . . ." Id. p. 1163.

In a Maryland case involving the standard of care in the emergency room of a medical care hospital, the Maryland Court of Special Appeals noted:

> "[The standard of care] was forcefully related by plaintiff's star witness. . . .
>
> "'This is a document called the Accreditation Manual for Hospitals. It's put out by the JCAH which is the Joint Commission on Accreditation for Hospitals, and what it does is it tells us at the hospitals when they inspect us for accreditation what they are going to look at, what questions they are going to ask, what minimum standards we have to do.'
>
> "We are always allowed to do more or be more thorough than this manual suggests . . . but this tells us the least that we have to do for them to accredit . . . ." Hahn v. Suburban Hospital, 54 Md. App. 685; 461 A.2d 7 (1983).

At the hearing, Dr. Novello, who is the Director, Child and Adolescent Services at the Psychiatric Institute, stated he was also representing Dr. Bates. Dr. Novello in a November 23, 1983, letter to the Hearing Officer stated:

> "Following the Hearing I have contacted Dr. Clark Bates by telephone. Dr. Bates has no additional written records and did not have any additional information pertinent to the case. He did stress to me, however, that the method and frequency of his progress notes were in keeping with the hospital standards and were consistent with numerous other CHAMPUS cases which he has treated in the past. He stressed that the level of care was consistent with an intensive hospital program for severely disturbed youngsters i.e. six times weekly group therapy, twice weekly individual therapy for an hour each time, frequent short individual contacts, and a weekly meeting with parents. On the matter of the medical necessity for [the beneficiary's] hospitalization from March 25 to May 7, Dr. Bates did not offer any additional information but stressed that he felt the record and the comments offered by [the sponsor and his wife] at the Hearing were adequate documentation for medical necessity."

A private psychiatric hospital must be accredited by the JCAH to be an authorized CHAMPUS provider. In this appeal, therefore, the Psychiatric Institute of Washington, DC, was required by the CHAMPUS regulation to adhere to JCAH standards for medical records in support of the beneficiary's inpatient psychiatric care. In addition, under the JCAH Manual, professional staff of the Psychiatric Institute of Washington, DC, must also satisfy the JCAH standards for patient records, treatment plans, and progress notes. The individual psychiatrists with the Metropolitan Psychiatric Group, therefore, when exercising staff privileges at the Psychiatric Institute of Washington, DC, as the admitting or treating physicians, must adhere to the JCAH standards for medical records in support of the beneficiary's inpatient psychiatric care.

The JCAH standards are more than "style." The preface to the 1981 JCAH Consolidated Standards Manual states that in compiling the edition:

> "JCAH staff considered the suggestions of thousands of health care professionals involved in the day-to-day provision of services to psychiatric, mental health, and substance abuse patients. Staff also consulted with numerous experts and relevant national organizations. As a result JCAH staff believe that these standards represent sound health care principles. . . ." (Emphasis added.)

The adequate documentation that CHAMPUS requires in support of the medical necessity and appropriateness of inpatient psychiatric care is, at a minimum, compliance with JCAH standards that must be met for a psychiatric hospital to be an authorized CHAMPUS provider. (If more demanding standards are required by the District of Columbia, since that is where the care was provided, then those standards would have to be satisfied.) The inpatient therapy, whether it was group or individual therapy provided by the Metropolitan Psychiatric Group, has not been documented in accordance with the requirements of the JCAH and it is, therefore, not in compliance with the requirements of the profession and of the CHAMPUS regulation. In the absence of any other credible evidence establishing the performance and medical necessity of care, CHAMPUS claims must be denied. The providers note that CHAMPUS has previously cost-shared care for other beneficiaries, but there is no showing that CHAMPUS ever requested and reviewed the medical records in prior instances or that CHAMPUS was aware of the issues and problems brought out in this appeal.

The JCAH standards provide, "Progress notes shall be used as the basis for reviewing treatment plans." The providers have not submitted progress notes and so have made it impossible to review the treatment.

The beneficiary was hospitalized for therapy. It is the progress notes from the therapy rendered that are the key to a review of her treatment. There were no progress notes from a single group or individual therapy session; a total failure by the provider to comply with JCAH standards.

The "progress and planning notes" found in the appeal record are more in the nature of multidisciplinary case conferences. The JCAH requires:

> "18.3. Multidisciplinary case conferences shall be regularly conducted to review and evaluate each patient's treatment plan and his or her progress in attaining the stated goals and objectives.
>
> "18.3.1. Multidisciplinary case conferences shall be documented and the results of the review and evaluation shall be recorded in the patient's record."

Although the records prepared by the professional providers are labeled progress notes, they are not progress notes. They totally fail to document the therapy provided in individual or group sessions. Summaries from a multidisciplinary case conference are not a substitute for progress notes.

The Hearing Officer recommended that two therapy sessions per month be allowed. This appears to be based, in part, on the erroneous assumption that two "progress notes" per month were prepared. As noted above, the progress notes were more in the nature of summaries of multidisciplinary case conferences and were sometimes only prepared once per month. And, as described above, they did not address the therapy sessions; therefore, the progress notes do not adequately document the claimed therapy sessions.

Even if the inpatient setting after November 4, 1981, had been determined to be medically necessary and at the appropriate level of care, the psychotherapy sessions claimed under CHAMPUS must still be adequately documented. I find that the individual therapy sessions billed by the professional providers were not adequately documented and, in fact, were not documented at all. Therefore, all claims for therapy sessions from October 5, 1981, to May 7, 1982, are denied CHAMPUS cost-sharing due to inadequate documentation necessary to establish the medical necessity or appropriateness of the therapy in dispute.

Inaccurate/False Billings

The billings for therapy, which Dr. Bates calls "an accurate record" are for individual therapy - some 151 individual therapy sessions. The only service/procedure code listed - 90805 - is for individual therapy. The code is from the CHAMPUS appendix

for psychiatric and psychological procedures. Not a single group session was billed. The CHAMPUS claim form provides:

> "PROVIDER CERTIFICATION - ITEM 33
> By signing item 33 of the CHAMPUS/CHAMPVA Claim Form 500, I certify that the specific medical services/supplies listed on this form were, in fact, rendered to the specific beneficiary/patient for which benefits are being claimed; were rendered or provided on the specific date(s) indicated; and that except for any amounts shown in item 30 and 31, no payment has been received."

Dr. Stone's treatment plan dated November 1981 stated there were weekly therapy sessions; Dr. Bates stated in his correspondence there were twice a week individual sessions. Yet CHAMPUS was billed for five individual sessions per week.

The daily staff notes for February 4, 1981, included a statement by the beneficiary that "her primary doctor and social worker were not in today." CHAMPUS was billed for a therapy session on February 4 by Dr. Bates. The notes for March 24, 1982, state the beneficiary was on bedrest. A therapy session was billed for March 24. These 2 days may only represent isolated instances, but they illustrate that a billing statement is not medical documentation of the care rendered.

It was indicated in the record that the professional provider was aware that CAMPUS will only cost-share a maximum of five 1-hour sessions in any 7-day period and, therefore, only billed CHAMPUS for five sessions even through more were rendered. There is no indication that the sponsor or beneficiary were ever billed for the sessions in excess of the CHAMPUS maximum. It is laudable when a physician for ethical or charitable reasons foregoes a charge. However, when a provider routinely foregoes a charge for services not covered by insurance or by programs like CHAMPUS, it raises the question whether there is over-billing for the services charged to compensate for the services which were not billed. I consider this a legitimate area of inquiry by CHAMPUS in any review of claims by this provider. An accurate billing of the services claimed to have been rendered (two individual sessions and six group sessions per week) would result in a lower allowable amount than what was originally allowed.

When a claim lists services not rendered, such as in this case five instead of two individual sessions, it is not an accurate billing. Such a claim is <u>not</u> to be rewritten by the fiscal intermediary or OCHAMPUS to allow two sessions (even assuming two (or more) sessions per month were documented), the claims(s) should be rejected in its entirety.

It would be unduly mild to call the billing records inaccurate. It could be considered to constitute a false billing to certify that individual therapy sessions were rendered, if

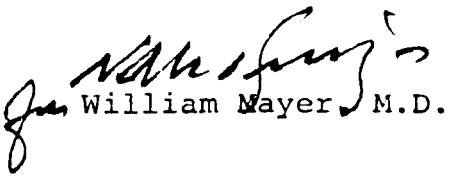
group therapy was provided. Since the testimony and correspondence state there were no additional records, there is no need to consider a revised billing. Reconstructed records are not acceptable. Therefore, the billings for psychotherapy are denied CHAMPUS cost-sharing for the additional reason that the billings do not accurately reflect the care rendered.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the medical necessity of the inpatient setting after November 4, 1982, was not established. The record supports a determination that after the 30-day diagnostic admission, the care could have been performed in a residential treatment center and that the inpatient setting was above the appropriate level of care. Therefore, coverage of the entire episode of care from November 5, 1981, to May 7, 1982, is denied CHAMPUS cost-sharing as being above the appropriate level. Only the inpatient hospital care from October 5, 1981, to November 5, 1981, the psychological testing by Dr. Brown, and the neurology consultation services of Dr. Rickler during the first 30 days of hospitalization may be cost-shared by CHAMPUS as medically necessary.

The CHAMPUS claims for inpatient psychotherapy services provided by Metropolitan Psychology Group psychiatrists, Dr. Bates, Dr. Stone, Dr. Fischman, and Dr. Herschberg, from October 5, 1981, through May 7, 1982, cannot be cost-shared as billed as there was not adequate medical documentation of the therapy sessions, the documentation did not comply with required JCAH standards, and the claims submitted were wrongfully certified as being for individual therapy although there is evidence that approximately 75 percent of all therapy rendered was group therapy.

The Director, OCHAMPUS, is directed to review the beneficiary's claims and to take action as appropriate under the Federal Claims Collection Act to recover any erroneous payments issued 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.



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