ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

JAN 2 3 1985

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 83-08
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD (HA) Case File 83-08 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party in this case is the beneficiary, a 23-year old son of a retired officer in the United States Air Force. The appealing party was represented at the hearing by his father.

The appeal involves the question of CHAMPUS cost-sharing of individual, group, and marathon psychotherapy provided the beneficiary from February 14, 1978, through January 14, 1979. The total charge for the services for these dates was approximately $11,210.00. The CHAMPUS Fiscal Intermediary initially denied cost-sharing because the institution, the Casriel Institute, was considered a halfway house and, as such, was not an authorized CHAMPUS provider. After the Informal Review, OCHAMPUS determined that the Casriel Institute was a residential treatment center rather than a halfway house. However, this facility was not an authorized residential treatment center because it had not received CHAMPUS approval; therefore, CHAMPUS cost-sharing was denied.

The Hearing File of Record, the tapes and oral testimony presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. The amount in dispute is $11,210.00. It is the Hearing Officer's recommendation that the First Level Appeal Decision be upheld in part and reversed in part, as follows: CHAMPUS should treat Dr. Casriel as an authorized professional provider, cost-share for psychotherapy services up to 1 hour in 24 hours for more than two times per week, i.e., each day psychotherapy services were provided, and not exclude the minithon therapy session as excluded marathon psychotherapy. The Hearing Officer upheld the decision to deny crisis intervention psychotherapy.

The Director, OCHAMPUS, concurs in part, and nonconcurs in part, with the Hearing Officer's Recommended Decision. The Director, OCHAMPUS, recommends issuance of a FINAL DECISION by this office denying CHAMPUS cost-sharing of all psychotherapy services by Dr. Casriel. In accordance with Department of Defense Regulation, DoD 6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject the Hearing Officer's Recommended Decision. In the 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 with the Director, OCHAMPUS, and rejects that portion of the Hearing Officer's Recommended Decision which recommends CHAMPUS cost-sharing of psychotherapy up to 1 hour per 24 hours for each day that psychotherapy was rendered. The basis of this rejection is that the Recommended Decision fails to document that the treatment was medically/psychologically necessary and in keeping with the generally accepted norm for medical practice in the United States.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is therefore to deny CHAMPUS coverage of the psychotherapy services provided to the beneficiary at the Casriel Institute from February 14, 1978 through January 14, 1979, as not medically/psychologically necessary and not in keeping with the generally accepted norm for medical practice within the United States.

FACTUAL BACKGROUND

The record indicates that the beneficiary's social life since his early teenage years was centered around drugs. The record reflects that he began using drugs at age 12; started taking LSD at age 14; and has taken at least 150 "trips," including 30 "trips" in one month. By age 17 the beneficiary was using heroin and barbituates and had been a constant user of marijuana. Because of this drug problem, the beneficiary was frequently hospitalized. In 1972 the beneficiary received outpatient psychiatric treatment. At the conclusion of this treatment, hospitalization was recommended. Beginning in June 1973, the beneficiary participated in the Rockefeller Methodone Program. He came to this program as a referral by the courts with the condition that he complete the program. Also in 1973, while at the Ridge Hill Rehabilitation Center, the beneficiary cut his wrist. As a result of this incident, he was sent to the Westchester Medical Center, Vosburgh Pavilion, for observation. He was subsequently a patient at New York Hospital - Cornell Medical Center for approximately one year. In 1975 the beneficiary returned to the New York Hospital on his own initiative. In September 1975, he once again cut his wrist, requiring stitches. During this period, the beneficiary received psychotherapy for depression, but in December 1975 the

psychiatrist stated that she was no longer effective and that the beneficiary needed hospitalization.

In 1976 the beneficiary was prescribed Valium; however, because he abused his prescription, the attending physician began working with him to reduce the quantity. This physician once again urged hospitalization. The beneficiary eventually returned to New York Hospital and Stanford Hospital. He also entered the Drug Liberation House which is a psychiatrically oriented facility. However, the beneficiary ran away from this facility. Subsequently, in October 1976, his depression became so severe that he was placed in the Phelps Memorial Hospital Psychiatric Ward. This facility was unable to keep the beneficiary; therefore, he was referred to the White Plains Hospital Day Clinic. He overdosed in this facility and was revived by the White Plains intensive care unit. He was returned to the Westchester Medical Center for observation and then released to the Yapalater Day Hospital.

On February 28, 1977, the beneficiary overdosed and was revived by the Phelps Memorial Hospital intensive care unit. The beneficiary was then sent to the jail hospital psychiatric unit at Valhalla where he was placed under 24-hour surveillance. After his release from this facility, he was admitted to the Phelps Memorial Hospital Psychiatric Ward. Within 5 days of admission he cut his wrist. As a result, he was returned to the New York Hospital because the Phelps Memorial Hospital did not have the facilities to treat the beneficiary because of his suicidal tendencies. The New York Hospital transferred the beneficiary to the Westchester Medical Center for observation after he attempted to hang himself while an inpatient at this facility. It was the recommendation of the New York Hospital that he be committed to the state hospital. In August 1977, the beneficiary was transferred to the Rockland State Hospital. After the beneficiary had been an inpatient at the Rockland State Hospital for a period of 2 months, it was recommended that he be transferred as he was no longer psychotic and no longer displayed suicidal tendencies. The attending physician recommended that he seek treatment at the Casriel Institute which provided A.R.E.B.A. (Accelerated Reeducation of Emotions, Behaviors and Attitudes) therapy.

Upon admission to A.R.E.B.A. (the Casriel Institute) on October 11, 1977, the attending physician noted that this beneficiary was a well-developed, well-nourished, white single male. When admitted, the beneficiary was having auditory hallucinations from a chronic abuse of LSD and constant use of marijuana. The admission notes indicate that the beneficiary had abused heroin, LSD, marijuana, cocaine, and barbituates. The diagnosis was psychosis due to chemical abuse, severe character-disordered personality, and anxiety with depression. Initial therapy began the week following admission. Therapy included treatment by psychotropic medication, group therapy, and one-to-one counseling.

The progress notes, which were completed on a weekly basis, indicate the beneficiary began to adjust to his new environment and the structured program of A.R.E.B.A. However, he still continued to maintain thoughts of suicide. The progress notes indicate that 2 months after he was in this program he continued to think of drugs and suicide very frequently and often fantasized of these destructive modes. During the week of December 28, 1977, the beneficiary left the facility for approximately a 14-hour period. During the next week, the structure of his treatment was changed to include more individual counseling and included participation in emotional groups in the outpatient division of the Casriel Institute. During the week of January 25, 1978, it was noted that this youth continued to have recurring suicidal ideation as well as thoughts of drug use. The progress notes for the week of February 22, 1978, indicate that he still contemplated suicide. It was noted that the suicidal ideation of this beneficiary began to increase during the week of March 22, 1978. The notes for this week indicate that the beneficiary was standing near a window ledge contemplating jumping. As a result of this incident, the medication was increased.

During the week of May 31, 1978, the beneficiary once again absented himself from the facility for a 24-hour period. During this absence he injected heroin and drank a very large amount of alcohol. During the week of July 25, 1978, he was found fashioning a noose in his room which evidenced a continued suicidal ideation and occasional suicidal gestures. During the week of October 18, 1978, the beneficiary's schedule was changed to include 2 to 3 hours of emotional groups per day, Monday through Friday, as well as a full day minithon (an extended 8-hour group session) conducted on Saturdays.

During the weeks of November 22, 1978, and January 17, 1979, the beneficiary left the facility and obtained marijuana. During the week of January 24, 1979, the beneficiary's progress was reviewed. It was noted that in recent months this beneficiary's progress had been basically good although slow and seldom consistent. Because of a serious infraction he committed during the week of January 17, 1979, it was the decision of the attending psychiatrist that residential treatment was not, at that time, the best alternative. Therefore, it was decided to treat the beneficiary as an outpatient for at least 1 month, at which time the beneficiary's progress would be reviewed to determine the best course of action. When discharged from the Casriel Institute, the diagnosis was psychosis due to chemical abuse, severe character disorder personality, anxiety with depression. The prognosis was guardedly hopeful.

The treatment plan at the Casriel Institute included daily one-to-one and daily group therapy sessions with Dr. Casriel actively involved in both the one-to-one and group therapy sessions. The treatment also included involvement within the A.R.E.B.A. community by working as a member of the kitchen crew. This was done in order to develop the beneficiary's essential ego

strength so that he could function and hold a job. Because of the limited progress of this beneficiary during the first several months while in the program and because of his complaints of hallucinations and severe depression, a second psychiatrist provided psychopharmalogical treatment. This psychiatrist placed the beneficiary on a battery of psychothropic drugs which included Teractin, Navane, and Serax. Upon discharge from A.R.E.B.A., the beneficiary continued to be under the care of this psychiatrist who monitored his medication.

A review of the billing statements from the Casriel Institute indicates that beginning the week of December 20, 1977, the beneficiary received 3 hours of psychotherapy sessions 5 days a week, a consultation during the week, and an extended psychotherapy session of 8 hours during the week. This pattern continued with slight variation - some weeks a consultation was held, while in other weeks it was not. The only other variation in this pattern was that, for a 7-week period, the beneficiary did not receive the extended 8 hours therapy session.

The psychotherapy sessions conducted by Dr. Casriel consisted of individual counseling sessions of varying length depending on the specific needs of the patient. The duration of these sessions usually ranged from 45 minutes to 1½ to 2 hours. According to the attending psychiatrist, the only people involved in these sessions were the therapist, Dr. Casriel, and the patient. The 3-hour therapy sessions were group sessions. Each peer group therapy lasted from 2 to 3 hours and included approximately 8 to 12 people. There was only one group leader although other staff members may have been present to assist. All group sessions were conducted by Dr. Casriel. The extended therapy sessions of 8 hours, described as minithons, were group sessions consisting of approximately 12 to 14 people and lasting 8 hours with two 1-hour breaks during the day. In these sessions, the group leader was also Dr. Casriel.

CHAMPUS claims for the period of February 14, 1978, through January 14, 1979, were filed with the CHAMPUS Fiscal Intermediary for New York, Blue Cross of Rhode Island. The fiscal intermediary initially denied the claims finding the A.R.E.B.A. program of the Casriel Institute was a halfway house and, therefore, not a benefit under the CHAMPUS. The sponsor requested an Informal Review. Subsequently, it was determined that the Casriel Institute could be classified as a residential treatment center rather than a halfway house; however, the facility was not an approved residential treatment facility under CHAMPUS. OCHAMPUS determined that Dr. Casriel could be an approved individual provider if it could be shown that he personally rendered services and customarily billed on a fee-for-service basis. Eventually OCHAMPUS determined the Casriel Institute including the A.R.E.B.A. program was not a CHAMPUS authorized provider; Dr. Casriel was recognized as an authorized individual professional provider by the CHAMPUS Fiscal Intermediary, Blue Cross of Rhode Island.

Concurrently with the determination that Dr. Casriel was an authorized individual provider, the fiscal intermediary allowed payment of claims on the basis of two outpatient visits per week. This determination was made on November 2, 1978. In addition to this, the fiscal intermediary began to conduct a review to determine whether more than two outpatient visits per week could be allowed.

On March 3, 1979, the sponsor requested a First Level Appeal on the basis that additional psychotherapy should be allowed because crisis intervention psychotherapy was medically necessary. During the review by OCHAMPUS, the case file was forwarded to the American Psychiatric Association for medical review by three psychiatrists to determine: (1) whether the prolonged and intensive individual and group psychotherapy was medically/psychologically necessary; (2) whether the beneficiary required crisis intervention psychotherapy during the entire treatment episode; and (3) whether the prescription drug therapy was appropriate for this beneficiary.

Two of the reviewing psychiatrists were of the opinion that the intense psychotherapy intervention was necessary for the beneficiary; however, crisis intervention psychotherapy was not medically/psychologically necessary. They also stated the level of care was inappropriate and unnecessary, and the prescriptions given this beneficiary appeared to be at an inappropriate dose, i.e., a level far below usual treatment. The remaining reviewer indicated that the case file supported the need for psychotherapy sessions, group and individual, beyond 2 hours per week, that the level of treatment was justified, that crisis intervention psychotherapy was not necessary, that services do not appear to be overutilized, and that the drug therapy and the level of care were appropriate. Further, it was the opinion of this reviewer that this beneficiary represented a severe psychiatric disturbance which he would characterize as severe borderline syndrome with intermittent episodes with overt psychosis. Although he indicated that the A.R.E.B.A. program was not the standard hospitalized treatment, because this beneficiary had failed at previous hospitalizations, a total emersion intensive treatment program such as A.R.E.B.A. was the last resort for this patient. It was also his opinion that a patient of this type, who has not responded to previous conventional psychiatric treatment, would profit from the A.R.E.B.A. program.

The OCHAMPUS First Level Appeal Decision determined that CHAMPUS would not cost-share any psychotherapy services provided by Dr. Casriel. This determination was based on the finding that Dr. Casriel was not and cannot be a CHAMPUS authorized individual professional provider. Further, even if Dr. Casriel was an authorized professional provider, the decision denied the services provided by Dr. Casriel beyond two sessions per week as not medically/psychologically necessary for the treatment of the beneficiary's condition.

The sponsor requested a hearing which was held by Mr. William E. Anderson, Hearing Officer, on October 15, 1982. The Hearing Officer has submitted his Recommended Decision, and all prior levels of administrative reviews have been exhausted. Issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are whether the psychotherapy services provided by Dr. Casriel at the Casriel Institute A.R.E.B.A. program from February 14, 1978, through January 14, 1979, were: (1) provided by a CHAMPUS authorized individual professional provider whose claims may be reviewed on an outpatient basis; (2) whether individual psychotherapy provided by Dr. Casriel beyond 1 hour in a 24-hour period from February 14, 1978, through January 14, 1979, was necessary for crisis intervention; (3) whether the "minithons" provided by Dr. Casriel from February 14, 1978, through January 14, 1979, were marathon therapy and thus excluded from the CHAMPUS Basic Program; (4) whether any of the psychotherapy provided by Dr. Casriel from February 14, 1978, through January 14, 1979, was medically/psychologically necessary and in keeping with the generally accepted norm for medical practice in the United States.

AUTHORIZED PROVIDER

The OCHAMPUS Regulation, DoD 6010.8-R, chapter II. B.17. defines an authorized provider as follows:

> "Authorized Provider. 'Authorized Provider' means a hospital or institutional provider, physician or other individual professional provider, or other provider of services and/or supplies specifically authorized to provide benefits under CHAMPUS in Chapter VI of this Regulation, 'Authorized Providers.'"

Chapter VI, B.1., of the regulation further defines authorized institutional providers in part as:

> "... those providers who bill for services in the name of an organizational entity (e.g., hospital, skilled nursing facility, etc.) rather than in the name of an individual."

Further, this section requires institutional providers, such as the Casriel Institute, to obtain CHAMPUS preauthorization to become authorized providers entitling them to CHAMPUS payment for services rendered. Because the Casriel Institute is not a CHAMPUS-authorized institutional provider, CHAMPUS cannot cost-share the inpatient charges at the Casriel Institute. However, claims submitted by Dr. Casriel for his personal services may be cost-shared as an individual professional provider if he bills on a fee-for-services basis and is not

employed or under contract with an institutional provider. The fact that these services may be provided at an unauthorized institution does not prohibit CHAMPUS cost-sharing of the individual professional provider's services. After my review of the record, I conclude that Dr. Casriel is an authorized individual professional provider because he bills on a fee-for-service basis, is not employed by or has a contract with an institutional provider, and personally provided the services. Therefore, OCHAMPUS may cost-share the services he provided the beneficiary subject to applicable statutory and regulatory restraints discussed below.

CRISIS INTERVENTION

DoD Regulation 6010.8-R, sets forth the psychotherapy limitations in chapter IV, C.3.i., as follows:

> "(1) Maximum Therapy for Twenty-four (24)-hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than (1) hour of individual and/or group psychotherapy 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."

The hearing record documents that the beneficiary, throughout the course of his many hospitalizations, entertained suicidal thoughts almost continually and, on several occasions, attempted suicide, including the period at the Casriel Institute where he manifested suicidal ideations and some acting out of these ideations. However, all three medical review psychiatrists associated with the American Psychiatric Association opined that crisis intervention therapy was not medically/psychologically necessary. Their opinions are based on the length of the psychotherapy and the lack of notes indicating in-depth therapy. I agree with these opinions. The record indicates the frequency of therapy was a preplanned course of treatment and was not dependent upon a crisis situation. The record does not document that crisis intervention therapy to be medically/psychologically necessary in this case; therefore, OCHAMPUS cannot cost-share in any crisis intervention psychotherapy.

MARATHON THERAPY

DoD Regulation 6010.8-R chapter IV., G.48., excludes mind expansion therapy as follows:

> "Mind Expansion. Services provided primarily for the purpose of mind expansion (that is increasing consciousness), including, but not limited to, Gestalt Therapy, Transactional

> Analysis, EST (Erhard), Rolfing, Transcendental Meditation, and Z - therapy."

Although marathon therapy is not specifically addressed in this provision of the regulation, it has been addressed in OCHAMPUS Interpretation 30-78-I, dated August 21, 1978. This interpretation provides as follows:

> "Marathon Therapy, a form of group therapy in which sessions last for an extended period of time (usually one or more days), is primary performed for purposes of personal enrichment or mind expansion. It is not considered by CHAMPUS to be necessary or appropriate treatment for mental or emotional disorders. . . Any charges made for Marathon Therapy . . . are to be denied in full. Because the modality itself cannot be considered necessary or appropriate, no portion of the charges are payable."

As previously indicated, Dr. Casriel billed for an 8-hour session, called a minithon, almost on a weekly basis. This minithon was an extended group therapy session which was aimed at breaking down emotional defenses and getting members in contact with their feelings. These sessions were conducted by the provider, Dr. Casriel. It is clear that the DoD Regulation prohibits cost-sharing for mind expansion experiences of any kind which are not actually related to the treatment of a mental or emotional disorder. It appears that the treatment received by the beneficiary during these minithons was not primarily for mind expansion but was for the treatment of a serious emotional problem related to drug abuse. Because the 8-hour minithons were not primarily for the purpose of personal enrichment or mind expansion, the Hearing Officer concluded that such therapy is not excluded under the Regulation as mind expansion and that the CHAMPUS Interpretation does not apply. I concur with this finding. The fact that the provider called these services minithons and referred to them as marathon therapy sessions does not automatically prohibit CHAMPUS cost-sharing.

MEDICAL NECESSITY/CARE IN KEEPING WITH THE GENERALLY ACCEPTED NORM FOR MEDICAL PRACTICE IN THE UNITED STATES

The Department of Defense Appropriations Act for 1976, Public Law 94-212, prohibits the use of CHAMPUS funds for ". . . any service or supply which is not medically or psychologically necessary to prevent, diagnose or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician, dentist, [or] clinical psychologist . . ." This restriction has consistently appeared in each subsequent Department of Defense Appropriation Act.

Department of Defense Regulation DoD 6010.8-R, chapter II, D.104, defines medically necessary as: ". . . the level of

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

The concept of medical/psychological necessity includes the requirement that medical services provided to CHAMPUS beneficiaries must be the appropriate medical care. Department of Defense Regulation DoD 6010.8-R, chapter II, B.14, defines appropriate medical care in part as: "That medical care where the medical services performed in the treatment of a disease or injury . . . are in keeping with the generally accepted norm for medical practice in the United States. . ."

As quoted above, the CHAMPUS Regulation, in the absence of documented crisis intervention, establishes maximum limits on CHAMPUS coverage of psychotherapy. CHAMPUS benefits are limited to no more than 1 hour of individual and/or group psychotherapy in any 24-hour period, and no more than five therapy sessions in any 7-day period. Having found that the crisis intervention was not medically/psychologically necessary in this case, a determination must be made regarding the maximum psychotherapy sessions CHAMPUS can cost-share.

Under these statutory and regulatory provisions, CHAMPUS coverage requires that psychotherapy treatment received at the Casriel Institute be medically/psychologically necessary (essential) for the care or treatment of a diagnosed condition and in keeping with the generally accepted norm for medical practice in the United States. A thorough review of the hearing file of record leads me to conclude that the psychotherapy treatment, including the minithons, for the period of February 14, 1978, through January 14, 1979, was not medically necessary nor in keeping with the generally accepted norm for medical practice in the United States. I am persuaded by the majority of the reviewing psychiatrists. As stated by Dr. Hamilton:

> "Although the beneficiary is indeed as described, a severely character-disordered individual who, apparently, has suffered various episodes of drug-related psychotic manifestations and while from the depth of his character disorder, there have been many behavioral acting-out episodes, some of which have been suicidal in nature, there does not seem to be any indication from the material presented that the level of intensity of psychotherapeutic intervention as allegedly provided for this beneficiary was, indeed, indicated. Since there are no specific notes relating to the in-depth therapy, itself, in terms of dynamics, indications, goals, and outcome for specific sessions or groups of sessions, it is difficult to even know what

> the intensive involvement claimed, actually occurred. I can see that in a setting such as A.R.E.B.A. there are numerous confrontational and encounter-type groups which are possibly supervised by some professional, or maybe even some para-professional, but these could not qualify under the rubric of intensive individual psychotherapy and it is doubtful that they could even qualify under the strict interpretation of group psychotherapy. Certainly, intensive individual psychotherapy provided by an adequately trained professional, would not have been indicated in this case for more than two sessions per week except during the times of crisis such as the suicidal acting-out episodes described in the folder when, for a brief period of time, additional sessions might have been necessary. In fact, I have doubts that the kind of intensive psychotherapeutic intervention as indicated by the provider for this beneficiary, is indicated in any case. There is grave doubt in my mind that an individual such as the beneficiary who is described as being on varying dosages of antipsychotic and anti-anxiety medication and suffering from time to time from psychotic responses, as a result of his chemical abuse, would be able to appropriately provide the concentration and emotional energy effort which would be needed to use this kind of intensive intervention."

Further, based on my review, it is my opinion that the treatments provided this beneficiary were not in keeping with the generally accepted norm for medical practice in the United States. There is no medical documentation justifying the lengthy and intense individual and group psychotherapy and no intermediate or long-range goals for the individual and group therapy were formulated. Finally, the treatment modalities used in the A.R.E.B.A. program are an unacceptable alternative standard of care in the United States at the time they were provided and continue to remain unproven and unfounded. In my opinion, the findings, opinions, and conclusions of the two peer reviewers (Doctor Langsley and Doctor Hamilton) are persuasive. The beneficiary may have benefited from a program such as the A.R.E.B.A program of the Casriel Institute; nevertheless, the treatment provided this beneficiary was not in keeping with the generally accepted norm for medical practice in the United States. Although the Hearing Officer found the services to be medically necessary, I find, based on a medical professional point of view, that these psychiatric services were not medically/psychologically necessary. For these reasons, CHAMPUS may not cost-share any of the psychotherapy services provided the

beneficiary at the Casriel Institute from February 14, 1978, through January 14, 1979.

MEDICARE ELIGIBILITY

At the hearing the sponsor disclosed that the beneficiary became eligible for Medicare, Part A, effective January 1, 1979. DoD 6010.8-R, chapter III, E.3.f., provides that CHAMPUS-eligible persons lose their eligibility for CHAMPUS upon eligibility for Medicare, Part A. Because this beneficiary became eligible for Medicare, Part A, effective January 1, 1979, the cost-sharing of services by CHAMPUS from January 1, 1979, to January 14, 1979, was erroneous and is subject to recoupment.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that Dr. Casriel is an authorized individual professional provider; and that the psychotherapy treatment received by the beneficiary from Dr. Casriel at the Casriel Institute for the dates of February 14, 1978, through December 31, 1978, may not be cost-shared because the services were not medically/psychologically necessary and not in keeping with the generally accepted norm for medical practice within the United States. Further, the claims for crisis intervention psychotherapy are denied. As the fiscal intermediary issued payment for psychiatric services after the beneficiary became eligible for Medicare, the Director, OCHAMPUS, is directed to review this case for appropriate action in accordance with the Federal Claims Collection Act. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

Vernon McKenzie
Acting Principal Deputy Assistant Secretary