ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

JAN 28 1985

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 84-52
deceased	)	FINAL DECISION
	)	
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-52 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing parties are the CHAMPVA beneficiary who represented herself and the treating hospital which was represented by its Assistant Credit Office Manager. This appeal involves the denial of CHAMPVA cost-sharing related to an inpatient stay in the appellant hospital from October 3, 1981, through October 24, 1981, and the attending physician's charges during the same period. The amount in dispute relates to $7,618.00 in billed charges for the 21-day hospitalization, and $1,200.00 in billed charges for psychiatric services provided by the attending physician. The actual amount in dispute is $6,613.50, which is the sum of the billed charges ($8,818.00) less the 25 percent beneficiary cost-share ($2,204.50).

The hearing file of record, the arguments presented by the parties to the Hearing Officer, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that only the first 3 days of hospitalization be approved; that charges for diagnostic tests conducted to determine the etiology of the beneficiary's physical complaints be allowed; that charges for the inpatient hospitalization subsequent to the initial 3-day period (the time during which the diagnostic tests reasonably could have been administered) be denied as not medically necessary and above the appropriate level of care; and that the services of the attending psychiatrist for individual psychotherapy provided during the entire period of hospitalization be allowed, but only to the extent allowable had they been provided on an outpatient basis.

The Hearing Officer found that the beneficiary suffered from an illness which involved significant physical symptoms and emotional distress. He also found that an initial period of

hospitalization (3 days) was medically necessary to conduct appropriate diagnostic tests. He further found that, based upon the results of those tests, the attending physician concluded that her psychiatric disorder was the major component of her illness and, therefore, proceeded with treatment for that disorder. The Hearing Officer concluded, based upon the evidence of record, that the treatment of the beneficiary, after an initial diagnostic stay, could have proceeded on an outpatient basis. The Hearing Officer's recommendations regarding the disposition of the claims at issue are based upon these findings and conclusions.

The Director, OCHAMPUS, concurs in the Recommended Decision and recommends adoption of the Recommended Decision as the FINAL DECISION. The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer and hereby adopts the recommendation of the Hearing Officer as the FINAL DECISION.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPVA cost-sharing for all but the initial 3 days of hospitalization; to allow charges related to diagnostic tests; and to allow charges for psychotherapy, but only to the extent allowable had such services been provided on an outpatient basis. This decision is based upon findings that: (1) the beneficiary suffered from an illness manifesting both physical and emotional symptoms; (2) an initial period of hospitalization was medically necessary to properly administer diagnostic tests and evaluations; (3) the necessary diagnostic tests and evaluations could have been properly administered with an inpatient stay of 3 days; (4) the beneficiary was determined to suffer primarily from a psychiatric illness; (5) psychotherapeutic treatment of this illness was medically necessary and appropriate; and (6) appropriate psychotherapy could have been administered on an outpatient basis subsequent to the initial diagnostic period.

FACTUAL BACKGROUND

The beneficiary is the widow of a 100 percent disabled veteran. She was admitted to the hospital on October 3, 1981, following approximately 4 months of care by the admitting physician. Her condition consisted of cirrhosis of the liver, constant, severe abdominal pain, nausea, and a weight loss of about 15 pounds. Upon admission, the admitting physician suspected that her primary disorder was psychiatric.

In the hospital the beneficiary underwent a broad series of diagnostic and psychological tests which resulted in the conclusion that the admitting physician's suspicions were correct and that her paramount problem was psychiatric. She continued in the hospital where she received inpatient psychotherapy until October 23, 1981. The claim for hospitalization services was denied by the fiscal intermediary, based upon a finding that the services rendered did not require an acute hospital level of care

and that medical management of the beneficiary could have been safely and effectively accomplished on an outpatient basis. The claim of the treating psychiatrist, in a billed amount of $1,200.00, was processed and paid by the fiscal intermediary. This claim was put in issue by OCHAMPUS as services related to an episode of inpatient hospitalization which was considered not medically necessary and not at an appropriate level of care. Both the beneficiary and the treating hospital appealed the fiscal intermediary's initial denial. Both also subsequently requested that the final step in the appeals process be conducted before a Hearing Officer but without an oral hearing. For this reason the Hearing Officer, Mr. William E. Anderson, has issued his Recommended Decision on the basis of the written record alone.

The Hearing Officer's Recommended Decision describes in detail the beneficiary's medical condition, the reasons for her hospital admission, the previous appeals that were made, the positions of the appealing parties, and the results of the medical review of the hearing record. Because the Hearing Officer adequately discussed the factual record, it would be unduly repetitive to further summarize it here, and, it is accepted in full in this FINAL DECISION. In view of the requests by the appealing parties for a hearing on the written record alone and the issuance of the Hearing Officer's Recommended Decision based thereon, the issuance of a FINAL DECISION in this case is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in their appeal is whether the inpatient hospitalization services provided to the beneficiary from October 3, 1981, to October 24, 1981, were medically necessary and at an appropriate level. A secondary issue, as identified by OCHAMPUS and the Hearing Officer, is whether cost-sharing of the services of the treating psychiatrist should be disallowed because they were sufficiently related to an inpatient hospital stay which was above the appropriate level required to provide medically necessary care.

The Hearing Officer in his Recommended Decision correctly stated the issues and correctly referenced the applicable law, regulations, and prior precedential FINAL DECISIONS in this area (OASD(HA) case file 06-80 and OASD(HA) case file 83-46) which were issued by this office on October 28, 1981, and December 23, 1983, respectively.

The Hearing Officer found that: (1) the battery of (diagnostic) tests should be cost-shared; (2) the first 3 days of inpatient hospitalization should be approved as medically necessary and (at) the appropriate level of care, constituting the period of time in which the tests reasonably (could have been) administered; (3) the inpatient hospitalization should be denied for the remaining days as not medically necessary and above the appropriate level of care; (4) the services of the

attending psychiatrist should be allowed up to the maximum allowed on an outpatient basis; and (5) the services (of the attending psychiatrist in excess of that allowance) should be denied.

I concur in the Hearing Officer's findings and recommendations. I hereby adopt in full the Hearing Officer's Recommended Decision, including the findings and recommendations, as the FINAL DECISION in this appeal. Because the Hearing Officer's Recommended Decision is being adopted in full in this FINAL DECISION, I have attached a copy of it to this FINAL DECISION and do hereby incorporate it as a part hereof.

In adopting the Hearing Officer's Recommended Decision in full, this office is approving his analysis and interpretation of the provisions of paragraph G.3., chapter IV, DoD 6010.8-R. I believe some background as regards the issue presented is in order. That paragraph specifically excludes "services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care."

In stating his rationale in support of his conclusion that the cited paragraph did not unconditionally operate to exclude the psychotherapy provided to this beneficiary, the Hearing Officer persuasively argued as follows:

> "If the regulation were intended to deny coverage for all services provided <u>during</u> an excessive hospitalization, it should have simply said that. In the absence of so clear a statement, however, we are required to determine what is intended by the term 'related to.' It would appear to mean more than simply 'contemporaneous with.' 'Related' as applies here is defined (<u>Webster's New Collegiate Dictionary</u>, 1973 Ed.) in the context of establishing a 'logical or causal connection between. . . .' In this sense, nursing or laboratory services or other services involving hospital personnel or facilities extended to a patient during an excessive period of hospitalization would be 'related to' the inappropriate period of institutional care. In such a case, there is such a logical or causal connection between the hospitalization itself and the ancillary services and supplies that they may truly be said to be 'related to' the hospitalization since they were caused by it and were a necessary part of providing the hospitalization although in itself it was not necessary. The psychiatric consults, although provided contemporaneous with the inpatient stay, are not 'related to' the

> inpatient stay in any fashion which involves a logical or causal relationship; they are not an integral part of hospitalization, and hospitalization conversely is not an essential element of the psychiatric consults. Psychiatric consults on an outpatient basis are not significantly different from psychiatric consults on an inpatient basis, except as to the location of the sessions. So the peer reviewer found in concluding that the psychiatric consults could have been provided on an outpatient basis."

In presenting its position to the Hearing Officer, OCHAMPUS argued that paragraph G.3. operated to exclude the attending physician's psychotherapy services in this case. This position was asserted apparently without regard to the medical necessity of the services because they were "related to" (apparently meaning "contemporaneous with" in the OCHAMPUS view) a period of hospitalization which was above the appropriate level. I agree with the Hearing Officer's rationale and finding that the position asserted by OCHAMPUS places an unduly narrow interpretation on the language of paragraph G.3. OCHAMPUS cited in support of its position OASD(HA) case file 83-46. That case involved the issue of whether a cardiac rehabilitation program provided to the beneficiary was medically necessary and constituted appropriate medical care. In finding that cardiac rehabilitation did not constitute appropriate medical care (i.e., care not in keeping with the generally acceptable norm for medical practice in the United States, a concept significantly different from "appropriate level of care"), we held that certain stress tests were "related to" the noncovered treatment modality and were thus excluded under paragraph G.66, chapter IV, DoD 6010.8-R. In that decision, the exclusion of the stress tests and other related ancillary services was predicated on a finding in that and other Final Decisions dealing with cardiac rehabilitation that such tests are an integral part of the cardiac rehabilitation program and have, in the context of such programs, no independent medical necessity or propriety. Thus, they may be said to be "related to" the noncovered care in the sense urged by the Hearing Officer, i.e., there is a logical or causal relationship between such tests and the cardiac rehabilitation program of which they are an integral part.

In reviewing other applications of the cited paragraph by this office, I find substantial consistency between them and the Hearing Officer's rationale which we are adopting herein. For example, in ASD(HA) case file 06-80, a case interestingly also cited by OCHAMPUS and followed by the Hearing Officer, we found a period of inpatient hospitalization for mental health reasons to be not medically necessary and above the appropriate level of care. Therein, we expressly stated as follows:

> "Although the evidence in the Hearing File of Record did not support the need for the inpatient confinement, it appears that some treatment was necessary. Therefore, CHAMPUS benefits can be provided for any individual psychotherapy rendered by the attending physician, on the basis of outpatient reimbursement. . . ."

In ASD(HA) case file 83-37, the beneficiary, who had suffered a broken leg, was recommended for discharge by her attending physician. She insisted, however, on staying in the hospital for personal reasons. We found the inpatient hospitalization beyond a certain date to be domiciliary care and denied benefits. The attending physician's fees beyond that date were also denied because they were "directly related to the domiciliary care and would not have been required had the beneficiary been in the home setting." However, even in this rather extreme situation, we noted that during the noncovered period X-rays and drug charges "would have been paid on an outpatient basis and are CHAMPUS benefits."

Finally, in ASD(HA) case file 83-51 (January 5, 1984), we found that an inpatient stay for alcohol rehabilitation was excessive and thus partially not medically necessary and above the appropriate level. Citing paragraph G.3., we stated that, "having determined that the beneficiary's last 14 days of hospitalization were not medically necessary and were above the appropriate level of care, all services and supplies, including physician care, related to that period of hospitalization are also excluded from CHAMPUS coverage." However, it had been noted earlier that in the context of this alcohol rehabilitation, the physician's treatment consisted only of screening, a psychological diagnostic interview, only five psychotherapy sessions and five group therapy sessions, and hospital visits which extended over the 35-day inpatient stay. All of this treatment was apparently directly related to the rehabilitation program because as noted by the Hearing Officer "Although (the attending physician) recalled a significant depression, there (were) no contemporaneous notes or records noting that concern, nor directing any specific treatment to that problem. No psychiatric evaluation appears to be suggested or conducted, nor was any medication given for depression." Under these circumstances, we found the attending physician's services to be an integral part of the alcohol rehabilitation program.

Based upon the foregoing, I conclude that the Hearing Officer has correctly distilled the unifying principle of the cited line of cases. That is, to be excluded under paragraph G.3., services must be "related to" the unauthorized inpatient stay in some fashion which involves a logical or causal relationship between the provided services and the beneficiary's inpatient status.

CHAMPUS benefits for outpatient psychotherapy are generally limited to a maximum of two therapy sessions per week. Medical review is required before benefits can be extended for more than two outpatient psychotherapy sessions per week. This case was subject to medical review on two separate occasions. On the second occasion the medical reviewer stated:

> "[The beneficiary] . . . continued to receive less-than-intensive inpatient treatment on a medical ward instead of a psychiatric inpatient unit. It is my further opinion, however, that she would not have been a candidate for the inpatient psychiatric level of care until it was clearly established that outpatient psychotherapy (up to the allowable benefit of twice weekly) was not successful in reducing her distress or relative disability."

It is clear that the medical reviewer determined that, at least initially, an outpatient program based upon twice weekly therapy sessions would have been appropriate for this beneficiary. Accordingly, I find that the maximum benefit allowable for the psychotherapy services which are being allowed herein is two therapy sessions per week.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to allow CHAMPUS cost-sharing for the first 3 days of inpatient hospitalization services (October 3 through October 5, 1981) and for all charges directly related to diagnostic tests; to deny CHAMPUS cost-sharing for all inpatient hospitalization services subsequent to October 5, 1981, (other than those directly related to the diagnostic tests); and to allow CHAMPUS cost-sharing of the services of the attending psychiatrist on an outpatient basis for up to two psychotherapy sessions per week. Because this FINAL DECISION modifies the manner in which both the claims for the inpatient hospital stay and for the services of the attending psychiatrist are to be processed, the Director, OCHAMPUS is instructed to review this case for appropriate payment or the initiation of recoupment action under the Federal Claims Collection Act consistent with the findings made herein. 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

RECOMMENDED DECISION
Claim for CHAMPUS/CHAMPVA Benefits
Civilian Health and Medical Program of the
Uniformed Services (CHAMPUS)

Appeal of	)	
	)	
Sponsor:	)	RECOMMENDED
(Deceased)	)	DECISION
	)	
SSN:	)	

This is the Recommended Decision of CHAMPUS Hearing Officer William E. Anderson in the CHAMPUS appeal case file of , and is authorized pursuant to DoD 6010.8-R, chapter X. The appealing party is the beneficiary. The appeal involves the denial of CHAMPUS/CHAMPVA cost-sharing for all except three days of inpatient hospitalization during the period of October 3, 1981 through October 24, 1981. The amount in dispute is $7,618 in billed charges for the 21 day hospitalization, and $1,200 in billed charges for psychiatric services provided the beneficiary.

This case was submitted on the record, at the request of the appealing parties, without hearing, and the hearing file of record has been reviewed. It is the OCHAMPUS position that the Formal Review determination, issued November 10, 1983, approving inpatient hospitalization for the first three days and denying cost-sharing for inpatient hospitalization for the additional days, be upheld on the grounds that the care beyond the initial three days was not medically necessary and appropriate medical care. It is the claimant's position that the entire hospitalization was necessary for evaluation purposes.

It is further the OCHAMPUS position that a bill for services of the attending psychiatrist, previously cost-shared by the fiscal intermediary, must be denied on the grounds of being a service related to the denied services.

Based upon due consideration of the Record, the Recommended Decision of the Hearing Officer is to uphold the OCHAMPUS Formal Review determination as to the inpatient hospitalization and to allow benefits for the necessary and appropriate psychiatric services in accordance with those benefits available on an outpatient basis on the grounds that such services were in themselves necessary and appropriate, and were not related to the services and supplies which were unnecessary and inappropriate, within the purview of the related services exclusion in the Regulation.

FACTUAL BACKGROUND

The patient was admitted to the hospital for examinations and treatment following a period of approximately four months of office

treatments by the admitting physician. The patient's conditions included cirrhosis of the liver, constant severe abdominal pain, nausea, and weight loss of about 15 lbs. By the time of the admission, the patient had become housebound and almost bed-ridden. The admitting physician suspected that the patient's primary disorder was a psychiatric disorder which had not responded to the use of psychotherapeutic drugs. The attending physician stated that the patient refused at that time to see a psychiatrist, however, as she had over the preceding three-year period during which she had been under his care.

The patient had a broad series of tests including EKG, radiological, neurological and gynecological examinations. By October 7 the progress notes indicate that the examining physicians were considering the psychiatric problems to be paramount. The notes for October 10 refer to the possibility of transfer to psychiatric services for further treatment of the patient's depression but the transfer does not seem to have taken place. It appears that the patient remained in the same facility or program during the entire hospitalization. The progress notes indicate that the somatization and nausea continued for approximately another 10 days until some improvement was noted on or about October 21, and the patient was discharged on October 23.

A claim for $7,618 was filed by the hospital with the fiscal intermediary in January, 1982. Apparently, the fiscal intermediary did not adjudicate the claim until March, 1983, when it issued the initial determination denying benefits on the grounds that the services rendered did not require an acute hospital level of care and that the medical management of the patient could have safely and effectively been accomplished on an outpatient basis. The fiscal intermediary's medical reviewer found that the patient was not acutely ill and the medical management of the patient could have been accomplished on an outpatient basis.

By letter dated April 6, 1983, the hospital requested an appeal of the initial determination denial and on June 21, 1983, the fiscal intermediary issued a Reconsideration decision reaffirming the finding that inpatient care was above the appropriate level and again denying benefits for the hospitalization because the level of care was above that required to provide necessary medical attention.

By letter dated August 5, 1983, the patient requested a review of the claim by OCHAMPUS. During the course of the Formal Review consideration, the medical record, including the physicians' letters, was examined by the OCHAMPUS Medical Director, a board certified psychiatrist.

A Formal Review decision was issued by OCHAMPUS on November 10, 1983, which affirmed the fiscal intermediary's denial of benefits for the patient's hospital stay for the period October 7 through October 24, 1981, but found that inpatient hospitalization from

October 3 through October 6, 1981, was medically necessary and appropriate medical care for purposes of the tests.

On January 3, 1984, the patient submitted a written request for a Hearing in this matter; on December 28, 1983, the hospital also requested a Hearing. By letters dated March 9, 1984, OCHAMPUS accepted both of the requests for Hearing. On March 27, 1984, OCHAMPUS granted the request of the appealing parties that the appeal be decided on the basis of the written record. The matter was referred to the undersigned Hearing Officer and the Hearing File was made available to the claimant.

Evidence received by the Hearing Officer consisted of the official file of documents duly transmitted to the Hearing Officer and the claimant consisting of Exhibits 1 through 29 and an Index of those Exhibits, together with the additional Exhibits consisting of a Notice of Hearing on the record, the Statement of OCHAMPUS Position, and the attachments thereto, including the April 30, 1984 Information Memorandum from Dr. Rodriquez, the CHAMPUS Work Sheet for Dr. Kenin, and copies of OSD(HA) cases numbered 06-80 and 83-46.

ISSUES AND FINDINGS OF FACT

The primary issue is whether the care provided the beneficiary was medically necessary and appropriate medical care as those terms are set forth in the applicable regulations, principally DoD 6010.8-R, chapters II and IV. The secondary issue is whether cost-sharing must be denied for the psychiatric services on the grounds that they were related to the services which were not medically necessary and appropriate.

Primary Issue

Medically Necessary and Appropriate Level of Care

CHAMPVA benefits are authorized by Congressional legislation incorporated in chapter 55 of title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in the Department of Defense Regulation 6010.8-R. Specific regulation provisions pertinent to this case are set forth below.

Chapter IV, subsection A.1., states that subject to any and all applicable definitions, conditions, limitations, and/or exclusions specified or enumerated in the regulation, CHAMPVA will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury.

Chapter II, subsection B. 104., defines "medically necessary" in part, as the level of services and supplies (that is, frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury and states that "medically necessary" includes the concept of "appropriate medical care."

Chapter II, subsection 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 acceptable norm for medical practice in the United States and specifies that the medical environment in which the medical services are performed must be at the level adequate to provide the required medical care.

Chapter IV, subsection G.1., states that services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury are specifically excluded from the CHAMPVA Basic Program.

Chapter IV, paragraph B.1.g., provides, in part, that for purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment.

Chapter IV, subsection G.3., specifically excludes services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

Chapter IV, subsection G.66., excludes all services and supplies (including inpatient institutional costs) related to a noncovered condition.or treatment.

The admitting physician in his report dated April 6, 1983, stated the following:

> This 55 year old female who had been under my care (as of 1981) for 3 years was known to have cirrhosis of the liver and a severe unclassified psychiatric disorder. She was hospitalized because office therapy for 4 months failed to control constant severe abdominal pain, nausea and a weight loss of about 15 lbs. By the time she was admitted, she had become housebound and almost bed-ridden. It was strongly suspected that her psychiatric disorder which had not responded to my use of psychotherapeutic drugs was a paramount part of her disorder. The patient refused, however, at that time (as over the entire 3 year period) to see a psychiatrist. Please see consultation by R. Michael Kenin, M.D. of 10/5/81 on this matter.
>
> I do not believe that successful outpatient management was possible. It had been tried for 4 months. May I report that after this stay and the institution of adequate psychiatric care, the patient has been well for the first time in a decade.

In his report dated December 13, 1983, he stated the following:

> . . has been under my care since 8/7/79. A diagnosis of alcoholic cirrhosis of the liver was clearly established in 1979. A psychiatric disorder which I was unable to adequately

diagnose was evident at that time and could be stated, by history, to have been present for many years. Depression was the most marked symptom of this problem. Please note that these dates are the correct ones and are at variance with those in the attached documents.

Treatment for cirrhosis was satisfactory but that for the psychiatric disorder was not. Many urgings to accept my plan for consultation and ongoing therapy by a qualified psychiatrist were ignored.

In the spring of 1981, on an office visit of 4/10/81 the patient reported being more anxious, having nausea on arising daily and feeling that her stomach filled up very rapidly. Further help in the form of psychiatric consultation and care was offered and refused.

She refused any further medical care from that time until October 81 but frequently reported (on the phone) worsening: increasely severe and frequent, then constant abdominal pain, nausea and vomiting and anorexia.

On admission studies for major medical illnesses, especially those known to complicate or associated with cirrhosis; hepatoma and ulcer disease, were performed as well as those to evaluate long standing urinary complaints. It was evident at that time that the psychiatric disorder was an important, possibly the major problem; it so proved.

She was found to be in an agitated depression. Her care, by Dr. Michael Kenin, who will be writing separately, proved difficult. She was slow to respond and numerous changes in drug therapy were needed. Dr. Kenin's frequent, detailed notes make it very clear of the need for intensive daily inpatient psychiatric care. When her disease was controlled she was discharged to Dr. Kenin's care. She has continued under his care since and has remained reasonably well controlled on ongoing psychotheraputic drug therapy.

These progress notes indicate that the various physical examinations were performed on October 5, 6 and 7. The psychiatric examination was on October 5 and the diagnosis was agitated depression with somatization. The psychiatrist made a recommendation on October 9 regarding her transfer to the psychiatric service for further treatment of depression. The patient continued through October 23 to have intermittent complaints of "bad nights", nausea, and the patient appears to have responded slowly to the psychotherapy and medication trials. The patient was discharged on October 23 to the psychiatrist's care on an outpatient care basis.

The record indicates that the patient had a serious problem which was apparently diagnosed accurately and treated in a manner consistent with the diagnosis, and the services rendered appeared to

have been useful to the beneficiary in identifying and working on resolving her particular disorder.

On the other hand, the proper administration of the CHAMPUS and CHAMPVA programs require that we consider at this time whether a 21 day inpatient stay was really necessary and appropriate. Chapter IV, subsection G.3. of the regulation specifically excludes services and supplies relating to inpatient stays in hospitals above the appropriate level required to provide necessary medical care. The term "medically necessary" refers to "the level of services and supplies, (that is frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury," it further states that "medically necessary" includes the concept of "appropriate medical care" which refers to the level at which services are provided, e.g. or whether they are appropriate, inadequate, or excessive.

A peer review evaluation was performed by Alex R. Rodriquez, M.D., CDR, MC, USN, Medical Director, Chief, Office of Quality Assurance for OCHAMPUS. He concluded (1) that "the treatments/evaluations were required to further determine the etiology of the multiple adbominal complaints," (2) that "these evaluations are considered to be medically necessary and appropriate to ascertain that the beneficiary had a primarily psychosomatic illness," (3) that "appropriate psychiatric treatment" was initiated and (4) that "the inpatient hospital setting was the appropriate level of care for three days."

In support of those conclusions, he is of the opinion (1) that all of the required evaluations and initial treatments could have been rendered during a three day inpatient hospitalization, and (2) that the medication trials and supportive psychotherapy for the agitated depression "did not require further inpatient care but could have been rendered on an outpatient basis." Further, in his opinion "the record indicates that this patient remained in the hospital for periodic psychiatric follow-up examination evaluations while various antidepressants and anti-anxiety medications were tried. While the psychiatric evaluations were indicated, they could have been performed as an outpatient. The patient's alleged ostensible resistance to psychiatric contact prior to admission would not have been a justification to maintaining her in the hospital until she 'felt better.'"

The Medical Director stated further that in his opinion "this is a case which demonstrates poor concurrent hospital utilization review. This hospitalization could not have been maintained for this length of time in most hospitals with active case monitoring, and certainly would be challenged by most contemporary peer review systems."

Based on the foregoing opinions of all the doctors and the medical documentation, the undersigned Hearing Officer finds and concludes (1) that the battery of tests, referred to as "treatments/evaluations"

by Dr. Rodriquez, was medically necessary and appropriate, (2) that an inpatient hospitalization for three days was necessary and appropriate, (3) that the portion of the billed charges representing those items should be cost-shared, but (4) that the inpatient hospitalization in excess of three days should be denied. The psychiatric services which have previously been cost-shared are discussed hereinafter.

Secondary Issue: Related Charges

Related Charges

In addition to the $7,618 in billed charges for the inpatient hospitalization, the evidence incidates that there was an additional bill submitted to the fiscal intermediary for services provided by the attending psychiatrist between October 5 and October 23, 1981, in the amount of $1,200 of which $940 was allowed (for a payment of $705 after deducting the patient's cost-sharing).

The OCHAMPUS Statement of Position observes that when a denial of coverage is appealed to OCHAMPUS, the entire episode of care must be taken into consideration and there is always the possibility that a previously paid claim will also be denied cost-sharing as a part of this appeal process, since the appeal process is not limited to segments of a claim. Also, the weight of authority from prior OCHAMPUS Final Decisions issued at the ASD(HA) level indicates that the principle of estoppel does not apply to actions of the Federal government, including actions through its duly constituted agents, the fiscal intermediaries. See, for example, the Final Decision in case number OASD(HA) File 83-46. The Hearing Officer concludes that the foregoing principles are applicable and that a review of the entire episode of care is therefore necessary and appropriate.

It is further the OCHAMPUS position that all related professional services in this case must be denied benefits under provisions of the regulations which exclude all services and supplies related to inpatient stays above the appropriate level. According to the OCHAMPUS position, if the inpatient stay from October 7 through October 24, 1981, was above the appropriate level of care and is to be excluded from cost-sharing, then all related professional services must also be denied, including the psychiatric consultations.

In this particular case, however, the rationale for denying cost-sharing of the inpatient hospitalization from October 7 through October 24, 1981, was the proposition that the patient needed psychiatric treatment rather than hospitalization for an acute physical problem. The peer reviewer felt that psychiatric treatment could have been provided on an outpatient basis. There is no peer review or other indication that the psychiatric services were not necessary or appropriate; rather, there is ample evidence that they were necessary and appropriate and there seems to be no disagreement as to that. The OCHAMPUS position is that although psychiatric services would

have been appropriate on an outpatient basis, they were "related" to excessive inpatient hospitalization benefits and that this in turn means that they should be denied.

The specific regulation applicable to this issue provides the following:

> "Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care." Chapter IV.G.3.

The aspect of this case which was "above the appropriate level required to provide necessary medical care" was the excessive duration of the inpatient hospitalization. The psychiatric consultation itself was not inappropriate. To the contrary, the psychiatric consultation was recommended by the peer reviewer as an alternative to the inpatient hospitalization. The question, then, is whether psychiatric consultation which everyone agrees was necessary and appropriate must be excluded under chapter IV.G.3. because it was provided during an excessively long hospitalization.

If the regulation were intended to deny coverage for all services provided during an excessive hospitalization, it should have simply said that. In the absence of so clear a statement, however, we are required to determine what is intended by the term "related to." It would appear to mean more than simply "contemporaneous with." "Related" as applies here is defined (Webster's New Collegiate Dictionary, 1973 Ed.) in the context of establishing a "logical or causal connection between . . . ." In this sense, nursing or laboratory services or other services involving hospital personnel or facilities extended to a patient during an excessive period of hospitalization would be "related to" the inappropriate period of institutional care. In such a case, there is such a logical or causal connection between the hospitalization itself and the ancillary services and supplies that they may truly be said to be "related to" the hospitalization since they were caused by it and were a necessary part of providing the hospitalization although in itself it was not necessary. The psychiatric consults, although provided contemporaneous with the inpatient stay, are not "related to" the inpatient stay in any fashion which involves a logical or causal relationship; they are not an integral part of hospitalization, and hospitalization conversely is not an essential element of the psychiatric consults. Psychiatric consults on an outpatient basis are not significantly different from psychiatric consults on an inpatient basis, except as to the location of the sessions. So the peer reviewer found in concluding that the psychiatric consults could have been provided on an outpatient basis.

The psychiatric services which were appropriate are not related to the inappropriate aspects of this patient's treatment, which was the excessive inpatient hospitalization and the associated facilities and personnel costs necessary to maintain that inpatient hospitalization. To the contrary, psychiatric consults were reasonable

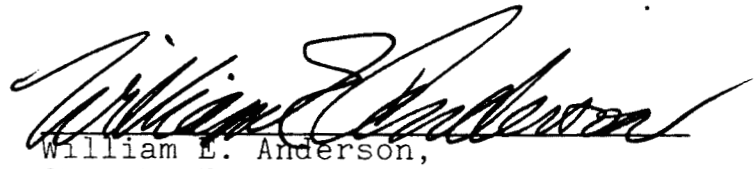
and necessary and their reasonableness is not diminished by the inpatient setting, which is itsellf denied benefits. It is the conclusion of the undersigned Hearing Officer that psychiatric services which are otherwise appropriate for cost-sharing are not "related to" those billed charges for inpatient care which are above the appropriate level of care as that term is used in the regulation.

Authority for such a conclusion appears in a Final Decision in OASD(HA) Case File 06-80, where the Assistant Secretary considered a case in which the evidence did not support the need for inpatient confinement but it appeared to his satisfaction "that some treatment was necessary. Therefore, CHAMPUS benefits can be provided for any individual psychiatric therapy rendered by the attending physician, on the basis of outpatient reimbursement limited to two sessions per week (not to exceed one hour per session)."

It is therefore the opinion of the undersigned Hearing Officer that the beneficiary is entitled to cost-sharing for the psychiatric services provided, but within the provisions of the Regulation for cost-sharing outpatient psychiatric services. The applicable subsection would appear to be chapter IV,C.3.i(1) for one hour of psychotherapy in 24 hours and chapter IV.C.3.i(3) for a maximum of two sessions per week. The Explanation of Benefits form is not available and the fiscal intermediary's calculation of benefits for the psychiatric services is not entirely clear, but it is the conclusion of the undersigned Hearing Officer that the patient should be entitled to cost-sharing in accordance with the foregoing principles and that OCHAMPUS might properly consider recoupement for the balance if necessary only after allowing benefits accordingly.

SUMMARY

In summary it is the conclusion of the undersigned Hearing Officer (1) that the battery of tests should be cost-shared, (2) that the first three days of inpatient hospitalization should be approved as medically necessary and the appropriate level of care, constituting the period of time in which the tests would have reasonably have been administered, (3) that the inpatient hospitalization should be denied for the remaining days as not medically necessary and above the appropriate level of care, (4) that the services of the attending psychiatrist should be allowed up to the maximum allowed on an outpatient basis, and (5) that those services in excess of that allowance should be denied.



William E. Anderson,
CHAMPUS Hearing Officer