ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

FEB 4 1985

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

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
	)	
Sponsor:	)	OASD(HA) File 84-57
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-57 pursuant to 10 U.S.C. 1071-1092, and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary who was represented by her husband, an active duty Major of the Wisconsin National Guard. The appeal involves the denial of CHAMPUS cost-sharing for inpatient alcoholic rehabilitation provided by the Hazeldon Foundation for the period of October 24, 1977, through March 22, 1978. The amount in dispute is approximately $6,951.00.

The hearing file of record, the tape of oral testimony, the verbatim transcript of the testimony, the argument presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that the inpatient alcoholic rehabilitation provided to the beneficiary from October 3, 1977, through October 31, 1977, be cost-shared by CHAMPUS because the inpatient care for this period was medically necessary and provided at the appropriate level. The Hearing Officer further recommends that the inpatient care for the period of November 1, 1977, through March 22, 1978, be denied CHAMPUS cost-sharing because the inpatient care for this period was not medically necessary and was provided on an inappropriate level in that the beneficiary was not suffering from a medical complication associated with alcohol withdrawal necessitating continued inpatient care.

The Director, OCHAMPUS, partially concurs in the Recommended Decision and recommends adoption of the Recommended Decision as the FINAL DECISION insofar as it denies CHAMPUS cost-sharing of the inpatient care from November 1, 1977, through March 22, 1978. The Director, OCHAMPUS, recommends rejection of that portion of the Recommended Decision which recommends that CHAMPUS cost-shares the outpatient care from October 24, 1977, through October 31, 1977. Under Department of Defense Regulation

6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject all or part of 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 that CHAMPUS cost-share the inpatient care from October 24, 1977, through October 31, 1977. The rejected portion of the Hearing Officer's Recommended Decision fails to consider the lack of evidence to indicate that the beneficiary, during this period, suffered from a medical complication associated with alcohol withdrawal necessitating continued inpatient care beyond 21 days. Further, the Hearing Officer's recommendation is contrary to the regulation and previous FINAL DECISIONS. These authorities are clear and specific. Absent evidence to indicate the beneficiary was suffering from a medical complication associated with alcohol withdrawal, CHAMPUS cannot cost-share inpatient care beyond 21 days. Thus, CHAMPUS can only cost-share the inpatient care provided from October 3, 1977 through October 23, 1977.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to allow CHAMPUS cost-sharing of the beneficiary's claim for inpatient alcoholic rehabilitation provided at the Hazeldon Foundation for the period of October 3, 1977, through October 23, 1977. It is also the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) to deny CHAMPUS cost-sharing of the beneficiary's claim for inpatient alcoholic rehabilitation provided at the Hazeldon Foundation from October 24, 1977, through March 22, 1978. This determination is based upon findings that the inpatient rehabilitation for the denied period was not medically necessary and was provided at an inappropriate level of care because the beneficiary, during this period, was not suffering from a medical complication associated with alcohol withdrawal necessitating continued inpatient care.

FACTUAL BACKGROUND

The beneficiary, at the time the care was rendered, was the spouse of an active duty Captain, United States Army. The beneficiary was admitted to the Hazeldon Foundation on October 3, 1977 for detoxification as a result of alcohol and drug abuse. The beneficiary remained in this facility until March 22, 1978, when she was discharged to a halfway house. During the course of the inpatient care the beneficiary received group therapy, occupational therapy, recreational therapy, bibliotherapy, lectures, counseling, and attended alcoholic anonymous meetings.

The Hearing Officer's Recommended Decision describes in detail the beneficiary's medical condition, the events leading to her referral to the Hazeldon Foundation and the course of treatment provided at the Hazeldon Foundation. Because the

Hearing Officer adequately discussed the factual record, it would be unduly repetitive to summarize the record and it is accepted in full in this FINAL DECISION. The Hearing Officer has provided a detailed summary of the factual background, including the appeals that were made and the previous denials, and the medical opinion of the medical review conducted under the auspices of the American Psychiatric Association.

The hearing was held on February 18, 1983, at Hazeldon Foundation, Central City, Minnesota, before CHAMPUS Hearing Officer, William E. Anderson. Present at the hearing were the sponsor, counsel for the Foundation, counsel for OCHAMPUS, and two witnesses from the Foundation. The Hearing Officer has issued his Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether the inpatient care provided the beneficiary in the extended care program of the Hazeldon Foundation from October 24, 1977, through March 22, 1978, was medically necessary and provided at the appropriate level of 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 02-80, and OASD(HA) Case File 80-04).

I concur with the Hearing Officer's findings to the effect that the inpatient care provided to this beneficiary from November 1, 1977, through March 22, 1978, is not available for CHAMPUS cost-sharing because the beneficiary, during this period, was not suffering from a medical complication associated with alcohol withdrawal necessitating continued inpatient care. I reject the Hearing Officer's finding that, ". . . the inpatient treatment given between October 25 and October 31, 1977, is within the parameter of extension of care in a particular case based on peer review concurrence." The record does not document that the beneficiary, from October 24, 1977, to November 1, 1977, was suffering from a medical complication associated with alcohol withdrawal necessitating continued hospitalization beyond the first 21 days. Accordingly, CHAMPUS cannot cost-share any inpatient care provided the beneficiary after October 23, 1977.

Secondary Issues

Throughout the course of the appeal and hearing, the sponsor has raised several issues concerning the CHAMPUS interpretation of medical necessity, the admissibility and reliability of the peer review, the absence of CHAMPUS alcoholism guidelines, the CHAMPUS 21-day limit for inpatient alcoholic rehabilitation, access to medical records, ex parte communications, request for specific findings, CHAMPUS payment at a lower level, and assessment of expenses. I concur in the Hearing Officer's

findings and recommendations with respect to all issues including the secondary issues as outlined in the Recommended Decision. Accordingly, I hereby adopt in full the Hearing Officer's Recommended Decision, including the findings and recommendations, as the FINAL DECISION in this appeal.

Administrative Correction

I do note on page 6 of the Recommended Decision under the heading, Issues and Findings of Fact, the Hearing Officer identified the period in dispute as October 25, 1977, through March 27, 1978. This is corrected to read: ". . . October 25, 1977, through March 22, 1978 . . ." as the beneficiary was discharged to a halfway house on March 22, 1978.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to authorize CHAMPUS cost-sharing of the inpatient alcoholic rehabilitation provided at the Hazeldon Foundation October 3, 1977, through October 23, 1977, and to deny CHAMPUS cost-sharing of the inpatient alcoholic rehabilitation provided at this facility from October 24, 1977, through March 22, 1978. This FINAL DECISION is based on findings the inpatient care from October 24, 1977, through March 22, 1978, was not medically necessary and was provided at an inappropriate level as the beneficiary was not suffering from a medical complication associated with alcohol withdrawal necessitating continued hospitalization. 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 Benefits
Civilian Health and Medical Program of the
Uniformed Services (CHAMPUS)

Appeal of	)	
	)	
Sponsor:	)	RECOMMENDED
	)	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 beneficiary , represented by who is both the sponsor and counsel of record. The appeal involves the denial of CHAMPUS benefits for inpatient alcoholism rehabilitation totaling $6,951 in billed charges between the period November 1, 1977 through March 22, 1978, and a review of benefits paid for the period October 25, 1977 through October 31, 1977 after an approved 21-day treatment.

The Hearing file of record has been reviewed. It is the OCHAMPUS Position that the extended inpatient care stay from October 25, 1977 through May 22, 1978 was above the appropriate level of care and not medically necessary. It is the appealing party's position that the extended inpatient alcohol rehabilitation treatment was appropriate and medically necessary. Based on the evidence of record, the Recommended Decision of the Hearing Officer is that the Formal Review Decision be upheld, allowing benefits between October 3, 1977 and October 31, 1977 and concluding that benefits for extended alcohol rehabilitation care between November 1, 1977 and March 28, 1978, are not provided pursuant to the applicable CHAMPUS regulations.

FACTUAL BACKGROUND

This appeal concerns extended care provided at a CHAMPUS-approved alcohol rehabilitation facility. On October 3, 1977, the patient was transferred to the rehabilitation facility for continuation of inpatient treatment begun approximately one week before when the patient was hospitalized following an episode of alcohol abuse. The patient was treated for alcoholism and chemical dependency, which was chronic in nature, at the facility. Benefits were allowed for 28 days, through October. Benefits were denied from November 1, 1977 through March 22, 1978.

An application for extended hospitalization and a medical statement from the attending physician dated November 16, 1977 were received in OCHAMPUS on December 3, 1977. The attending physician stated that the patient had a history of unsuccessful attempts of improving her mental health through detoxification and psychiatric treatment. The staff at

the rehabilitation facility recommended that the patient continue as an inpatient in the extended care program from four to six months.

The patient had engaged in serious episodes of alcohol and drug abuse since approximately September, 1972. During the five-year period she had made several suicidal gestures related to intermittent binges. She had a series of inpatient and outpatient treatments in a number of hospitals, and had attended the AA program but without success. Her Ph.D. dissertation involving research in medieval archives, on which she had been working while her husband was stationed in Germany, had foundered, an alternative enrollment in law school had ended in failure, and she was, by the late summer of 1977, involved in child custody legal battles with her then estranged husband. A drinking binge followed her move to an apartment and there was an overdose episode in connection with the actual transfer to the rehabilitation facility.

The patient entered the detoxification unit at the rehabilitation facility upon admission and was transferred to the primary rehabilitation center the following day, having been diagnosed as in no apparent distress during detoxification. She did not experience medical problems during her stay and was not on medication. She was placed in the extended care treatment plan located on the campus at the facility on November 20, 1977. The treatment plan included group therapy, occupational therapy, recreational therapy, spiritual guidance, lectures, bibliotheraphy, and counseling. She remained there until discharged to a halfway house on March 22, 1978.

A claim was filed for the inpatient care from October 3, 1977 through March 22, 1978, a period of 171 days, in the amount of approximately $1,450 per month. The fiscal intermediary allowed payment in the amount of $1,347.40 for 21 days of inpatient care. The sponsor appealed the determination for reconsideration by the fiscal intermediary. A direct Reconsideration Review occurred at the OCHAMPUS level because of a change in the applicable fiscal intermediary for handling this claim during its pendency.

The OCHAMPUS Reconsideration Review denied benefits beyond October 24, 1977 on the stated grounds of insufficient medical documentation. This was appealed within OCHAMPUS for a formal review. The sponsor's position with respect to the Reconsideration Review denial is that it was defective on the grounds that the requested medical records were available to OCHAMPUS upon request, were not available to him upon request and that he had made bona fide efforts to obtain them. The OCHAMPUS Formal Review Decision approved 28 days of inpatient care but denied benefits beyond October 31, 1977 on the grounds of lack of medical necessity and that the care was above the appropriate level of care.

The hearing requested by the sponsor was scheduled to be heard on February 18, 1983, notice was duly given and the matter duly heard by the undersigned Hearing Officer as scheduled. Persons present at the hearing included the sponsor, ; OCHAMPUS counsel, Karl E. Hansen; a witness, Dorothy Flynn, and Margaret Savage, counsel for the rehabilitation facility.

Evidence received by the Hearing Officer at the hearing included the official file of documents duly transmitted to the Hearing Officer and the sponsor prior to the hearing consisting of Exhibits 1 through 37 and an Index of those Exhibits, additional Exhibits 38 through 55 submitted at the hearing, and Exhibits 56 through 100 submitted thereafter, including additional information from the APA Peer Review program.

A motion by the sponsor for summary judgment was denied. The sponsor's motion to exclude the peer review from the record was also denied, but a subsequent request to serve interrogatories upon the reviewing physician was allowed and the answers are of record. The sponsor and OCHAMPUS counsel have subsequently filed various documents and memoranda, also of record and listed on the additional Exhibits Index. Among these, a set of Supplemental Interrogatories was filed by the sponsor, for which the sponsor was taxed the costs. The Hearing Officer subsequently, with the consent of the parties, struck those Supplemental Interrogatories and Answers from the official record for nonpayment of the bill of costs, although it is still attached to the other Exhibits. The defamatory portions of Exhibit 88 have been stricken from the Record in a similar fashion.

The evidence of record indicates that the patient's treatment out of which this case arises consisted of three phases: detoxification, primary care, and extended care. The detoxification consisted of approximately one day, the primary care consisted of approximately 35 days, and the extended care lasted approximately four and one-half months with a short home visit at Christmas.

At the time of the patient's admission at this facility in October, 1977, the patient then age 33, had experienced problems with alcohol abuse for approximately five years, since at least early September, 1972. At that time she and her husband, an active duty attorney in the army, were living in Germany where he was stationed. She had just finished graduate work except for the dissertation. By March, 1973, the patient was having serious drinking problems including a suicidal gesture. She underwent detoxification at two civilian hospitals in Germany and went through episodes of sobriety and intermittent binges throughout the remainder of the sponsor's tour of duty in Germany. In late 1973, she forsook the dissertation and in May, 1974, returned to America and enrolled in law school.

The husband/sponsor was transferred back to America in October, 1974, and characterizes her condition during that period as being a serious weekend drinker and heavily using prescription medications including valium and librium. She eventually consulted a psychiatrist at the university student health center. She rejected his advice and did not participate in therapy. She flunked out of law school, resumed residence with the sponsor on a post to which he was assigned and had another period of time in which there was not alcohol abuse but then there was subsequently another apparent suicide attempt or gesture as a result of which she was in the post hospital twice for combining pills with alcohol.

In approximately July, 1977, she was in the post hospital for a third time and was transferred to a civilian hospital. There was a subsequent

admission to a civilian hospital after an assaultive and threatening incident involving another possible suicide gesture. After a week or 10 days of inpatient treatment there she was transferred to outpatient treatment. The sponsor had filed for a legal separation, had obtained custody of the couple's son, although the son was at that time living with her in an apartment because of the sponsor's duty assignment. She recommenced her graduate studies in the fall of 1977. She was still experiencing a problem drinking situation and admitted herself to the student health center where she remained for several days from which she was subsequently transferred to the approved alcohol rehabilitation center. At the airport on the way there was another abuse of medication, described by the sponsor as a suicide gesture, with a number of haldol tablets.

The progress notes for October 3, 1977, consist primarily of an interview with the patient by the R.N. which concluded in part as follows: "Denies any physical limitations or disabilities. Would like to talk with psychiatrist. Will have Dr. Heilman see her tonight . . . 37 of 90)

The patient was seen by R. O. Heilman, M.D. on October 3, 1977, on the basis of a consultation request made by J. Flipse, R.N. Dr. Heilman's findings (Ex. 27, p. 1 of 90) were as follows:

> seems comfortable and even relieved to be here at Hazelden; "I really have no anxiety--it's remarkable." She is not anxious or depressed at this time.
>
> Her thought processes were flighty. Rambled on about being in Europe seven years, needing to get her hair fixed, wondering about sleeping all day and expecting to be awake tonite (sic), etc. Expressed no serious preoccupations. See her as quite an immature, very dependent lady expecting a lot of support and attention.
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> Recommendations:
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> 1. Matter-of-fact approach. Regular Rx.
>
> 2. No medications.

Upon transfer to the rehabilitation program on October 4, 1977, the progress notes indicate the following: "Discontinue checking vital signs at the time of transfer." (Ex. 27, p. 38 of 90)

A physical examination conducted on October 4, 1977 by W. W. Young, M.D. stated the following: "In general, a cooperative girl with a rather flat affect. HENT eyes PERRLA, EOMs intact. Throat is rather inflamed. Neck-supple, no thyroid enlargement. Chest-heart is a regular rhythum, no murmers. Lungs are clear to P&A. Breasts are soft, no masses. No hepatosplenomegaly. Bowel sounds are normal. Normal external genitalia. Good range of motion without edema. Neurol.-no focal findings. Impressions: Rule out chronic chemical dependency to drug and alcohol. Neurotic anxiety, chronic. This patient has been examined and is free of communicable disease." (Ex. 27,

p. 5 of 90) Clinical tests conducted on October 4, 1977, showed results within normal limits. The admission summary, under medications for medical problems, contains the designation "none." (Ex. 27, p. 6 of 90)

Ms. Dorothy Flynn, a counselor at the center, Hazelden, held the position in 1977 of Unit Coordinator of the extended care program. She testified essentially as follows:

The patient, as do most extended care patients, came through the primary care rehabilitation program. Upon an original admission, depending on the need for detoxification, a patient would spend from one to three days under observation for symptoms from withdrawal but is then gotten into the rehabilitation process as soon as possible. The Hazelden Foundation uses the treatment plan called the Minnesota Model which is a multi-disciplinary approach to alcoholism or chemical dependency as an illness involving a physical side, a psychological side, a spiritual side, and a social side. A seven-day assessment is typical and a rehabilitation plan devised. Between four and seven percent of the total inpatient population is referred to the extended care facility. Fewer than that are accepted. An admission to the extended care program involves various considerations, including satisfactory physical health and financial resources. Making progress is an essential element of remaining in extended care rather than being discharged. The particular aspects of this patient's case involving the recommendation that she participate in the extended care program are the lengthy chemical history involving both alcohol and drugs, the desocialization, the patient's perception as having no friends, discomfort in social situations, the marital separation and possible loss of child custody, being dependent, lacking assertiveness, lacking the ability to handle anger adequately or appropriately.

At the time of her transfer to the extended care facility, in Ms. Flynn's opinion, a "person presenting the kinds of problems had would not normally be considered for outpatient treatment." (Tr. p. 49) The alternative to extended care would be a halfway house. Consideration was given to a halfway house during the primary care and again during extended care. At that point in considering a treatment alternative for this patient, some efforts were made to find an appropriate halfway house but one was not found which appropriately matched patient, program, and population. The extended care referral was a result of a team conference. The team included counselors, a psychologist, a R.N. who was the quality control coordinator, and a clergyman. Review by a physician would occur while the patient is in primary care and the decision to place a patient in extended care is not reviewed by a psychiatrist. The extended care program is not designated to deal with serious psychiatric problems. This patient's history of three or four previous suicide attempts would not preclude her from being admitted to extended care. Ms. Flynn explained: "It is not that unusual for a chemically dependent person to verbalize thoughts of suicide or to have had some suicide attempts in their history." (Tr. p. 53) This patient's history of suicidal gestures was not a serious concern to the personnel at the extended care facility. She made no suicide attempts during either the primary or extended care. A significant portion of the drugs this patient had abused were drugs frequently prescribed in the treatment of withdrawal symptoms. At

the time of entering extended care and during extended care this patient did not have medical problems, except for perhaps a cold, which would have been treated by the medical staff rather than by a psychiatrist or a physician.

The facility treated approximately 1,500 patients during the year 1978 involving approximately 175 patients at a time in primary care of whom all but about four to seven percent are referred out to something other than the extended care facility. The patients in primary care are in the facility's "usual 28 to 32 day treatment period." (Tr. p. 58) This patient seems to have been a typical patient of the extended care program in terms of age, professional background, economic status, and combined alcohol and drug abuse.

The patient was discharged when she had received maximum benefit from the program, having improved from a "self-doubting, self-centered, unassertive woman" (Tr. p. 59) whose intellectual and scholastic achievements were of paramount importance to her but who had been devastated by having failed to complete her Ph.D. dissertation and having failed in law school, being extremely lacking in self-confidence and preoccupied by her uncertain marital status and child custody situation. By the end of the program she was able to cope with these problems, adequately asserting herself, expressing her anger and having a good level of self-confidence at the time of her discharge.

At the time of the initial admission she was not suffering withdrawal symptoms, she was not suffering any other medical condition that would be related to drug or alcohol abuse, and was not in distress. From reviewing her record as of the date of her admission the most significant items are the recent episode of drug or alcohol abuse, and the indication that she was anxious and confused and seen by a consulting psychiatrist and by a consulting psychologist on two occasions which was unusual. The patient was not suicidal at the time of admission to extended care. At that time the patient was not suffering a major effective disorder. Many people very much like this patient are referred to halfway houses after four to five weeks after initial admission without a significant detoxification. Such a referral would not have been unusual in this case. Such a referral was not made for two reasons: First, the primary treatment evaluation staff considered a halfway house as a second option after extended care and second, an appropriate halfway house was not available.

In Ms. Flynn's opinion extended care was an appropriate and effective treatment as opposed to some lower level or other level of care. The principal difference between the services available at Hazelden and those that would have been available at a suitable halfway house involve the amount of therapy and training and the more structured ability of the extended care program to provide graduated job-like responsibilities.

ISSUES AND FINDINGS OF FACT

The primary issues in dispute are whether the beneficiary's inpatient care in the extended care program of this alcohol rehabilitation facility from October 25, 1977 through March 27, 1978, was medically

necessary and was above the appropriate level of care as described in DoD 6010.8-R, chapter IV, B.14.a. and c.

Secondary issues that will be addressed include issues of (1) whether the term medical necessity is affected by law arising from medicaid and insurance including the concept of second-guessing the treating physician by the peer reviewer, (2) admissibility and reliability of the peer review opinion, including (a) the reviewer's qualifications, (b) the right to cross-examination, (c) limiting the review to medical records only, (d) whether peer review must be regional, (3) the absence of CHAMPUS alcoholism guidelines, (4) whether the 21-day norm is arbitrary and capricious, (5) procurement of additional medical records, including (a) those from the facility itself, (b) those from military and civilian hospitals, and (c) the denial of access to records in allegedly similar cases, (6) a claimed ex parte communication, (8) payment at a lower level of care, and (9) assessment of expenses incurred in developing the record.

PRIMARY ISSUES

Medical Necessity/Appropriate Medical Care

The CHAMPUS regulation, at DoD 6010.8-R, chapter II.B.104 and chapter II.B.14 provides the following:

> 104. Medically Necessary. "Medically Necessary" means the level of services and supplies (that is, frequency, extent, and kinds) adequate for the diagnosis and treatment of illness or injury (including maternity care). Medically necessary includes concept of appropriate medical care.
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> 14. Appropriate Medical Care. "Appropriate Medical Care" means:
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> a. That medical care where the medical services performed in the treatment of a disease or injury, or in connection with an obstetrical case, are in keeping with the generally acceptable norm for medical practice in the United States;
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> b. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed and/or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
>
> c. The medical environment in which the medical services are performed is at the level adequate to provide the required medical care.

Specific provisions of the regulation relating to the extent of CHAMPUS coverage of inpatient care for alcoholism, are DoD 6010.8-R, chapter IV, E.4., as follows:

4. Alcoholism. Inpatient hospital stays may be required for detoxification services during acute states of alcoholism when the patient is suffering from delirium, confusion, trauma, unconsciousness and severe malnutrition, and is no longer able to function. During such acute periods of detoxification and physical stabilization (i.e., "drying out") of the alcoholic patient, it is generally accepted that there can be a need for medical management of the patient if there is a probability that medical complications will occur in alcohol withdrawal, necessitating the constant availability of and/or complex medical equipment found only in a hospital service. Therefore, patient hospital care, during such acute periods and such conditions, is considered reasonable and medically necessary treatment of the alcoholic patient and thus covered under CHAMPUS active medical treatment of the acute phase of alcoholic withdrawal and the stabilization period usually takes from three (3) to seven (7) days.

a. Rehabilitative Phase. An inpatient stay for alcoholism (either in a hospital or through transfer to another type of authorized institution) may continue beyond the three (3) to seven (7) day period, moving into rehabilitative program phase. Each such case will be reviewed on its own merits to determine whether an inpatient setting continues to be required.

EXAMPLE

If a continued inpatient rehabilitative stay primarily involves administration of Antabuse therapy and the patient has no serious physical complications otherwise requiring an inpatient stay, the inpatient environment would not be considered necessary and therefore benefits could not be extended.

b. Repeated Rehabilitative Stays: Limited to Three (3) Episodes. Even if a case is determined to be appropriately continued on an inpatient basis, repeated rehabilitative stays will be limited to three (3) episodes (lifetime maximum); and any further rehabilitative stays are not eligible for benefits. However, inpatient stays for the acute stage of alcoholism requiring detoxification/stabilization will continue to be covered. When the inpatient hospitalization setting is medically required, a combined program of detoxification/stabilization and rehabilitation will normally not be approved for more than a maximum of three (3) weeks per episode.

c. Outpatient Psychiatric Treatment Programs. Otherwise medically necessary covered services related to

out-patient psychiatric treatment programs for alcoholism are covered and continue to be covered even though benefits are not available for further inpatient rehabilitative episodes, subject to the same psychotherapy review guidelines as other diagnoses.

There is no CHAMPUS regulation dealing specifically with extended care inpatient alcohol rehabilitation treatment centers as such by name. The provisions set out verbatim on page 8 of this Recommended Decision refer to inpatient treatment at a hospital.

"Hospital, Long Term" is defined in the regulation, at Chapter II.b.76. as follows:

> 76. Hospitals, Long Term (Tuberculosis, Chronic Care, Rehabilitation, etc.): "Hospitals, Long Term" means an institution which is primarily engaged in providing, by or under the supervision of a physician, appropriate medical or surgical services for the diagnosis and treatment of the illness or condition in which the institution specializes (i.e., tuberculosis and chronic diseases or conditions). Such long term hospitals must otherwise meet the same provisions as outlined in the definition of "Hospitals, Acute Care, General and Special."

It is therefore concluded that the regulation at chapter IV.E.4., Alcoholism, does apply to the inpatient alcohol rehabilitation program which this patient attended. The only applicable provisions in the regulation thus (1) do not specifically provide for "extended care" in the magnitude of four to six months, (2) do provide for inpatient care for a normative three to seven day period, with (3) inpatient care beyond that based on (4) review of each case on its own merits based on (5) "serious physical complications otherwise requiring an inpatient stay", without which (6) "the inpatient environment would not be considered necessary and therefore benefits could not be extended", which (7) has the effect of requiring an analysis of medical necessity and appropriate level of care in connection with each case.

The case was submitted to the American Psychiatric Association Peer Review Project by OCHAMPUS and referred to Ronald S. Mintz, M.D., whose response described the historical development of guidelines for inpatient alcoholic rehabilitation services. Dr.Mintz developed criteria for Blue Cross of Southern California in 1973 in which the "usual maximum length of stay was set at 25 days." (Ex. 29, p. 2 of 5) Medicare guidelines issued in 1976 established a "usual maximum length" for both detoxification and rehabilitation for 21 days. The Blue Cross/Blue Shield Federal Employees Program initiated in January of 1981 established the usual maximum length of stay as 28 days. A survey in southern California showed 80% of the alcoholic rehabilitation facilities using a usual maximum length of stay of three days or less for detoxification plus 21 days rehabilitation.

Dr. Mintz concluded that the particular rehabilitation program made available to this patient was a good program using the usual modalities

and being well-documented. He concluded as follows:

> This patient did not require alcoholic detoxification, and was entered into the rehabilitation program after a one-day observation period. I am persuaded that the staff anticipation of an "open-ended" six-month average length of stay treatment program likely affected the patient's rate of progress. In any event, she does not appear atypical in any major dimension. She was not suicidal, nor suffering from a major affective disorder. She had no serious complicating medical conditions. She was not a management problem. She did evidence passivity.
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> To respond directly to the questions posed:
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> Question 1. Based on the medical record, was the inpatient setting in the alcoholic rehabilitation program the appropriate level and medically necessary for medical management of the patient's condition and diagnosis for the period October 3, 1977 to November 8, 1977?
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> Response. The patient qualified as an appropriate patient for an inpatient alcoholic rehabilitation program (the Medicare guidelines would not have accepted her admission into an acute hospital setting for rehabilitation since she did not require the acute hospital setting for detoxification or for other complications of alcoholism. However, this requirement has not been adopted by most other public and private guidelines regarding coverage for alcoholic rehabilitation programs). She had a documented history of chronic alcoholism, with serious social and medical consequences, and her drinking was not in good control. While an outpatient alcoholic rehabilitation program would not have been beyond consideration, her lack of home support and her long drinking history would be two factors, among others, which would tend to make an inpatient program more likely to succeed than an outpatient program. The program itself seems a good one, and is exceptionally well-documented for 1977 (or even for today). The usual modalities of alcoholic rehabilitation programs are utilized. The patient participated in the program and the therapuetic observations and interventions are documented in considerable detail. There is some lack of documentation of medical supervision of the rehabilitation treatment, but I would not make an issue of this in a 1977 record. I find that the inpatient setting in the alcoholic rehabilitation program was the appropriate level and medically necessary for medical management of the patient's condition and diagnosis for the period October 3, 1977 to October 25 (one day observation plus 21 days rehabilitation), but would accept continuation of inpatient treatment for three to seven additional days on the basis that the patient's response was a bit slow regarding behavioral change. Beyond that point I find no documented need for continued inpatient

treatment as opposed, for example, to an organized outpatient alcoholic rehabilitation program.

He could "find no documented need for inpatient services after November 9, 1977" (which was when the transfer was made to extended care). Rather, in his opinion he concluded that the six months open-ended type of arrangement was probably self-fulfilling and that "if the expectation from the beginning had been for a three-four week period of inpatient treatment, there is no reason to anticiptae that this patient could not safely and effectively continue her treatment on an outpatient basis beginning November 2, 1977. While the passivity in her personality is a factor in the treatment, she is not markedly different from thousands of patients who are able to continue their treatment on an outpatient basis after a three-four week period of inpatient treatment." In his opinion a limited extension beyond the 21-day point would be appropriate: "On the basis of her passivity and characterlogical worry, a few additional days might be justified, from three to seven, for a maximum discharge date of November 2, 1977.

The claim for benefits for the first 21 days of treatment was originally allowed. The Formal Review Decision found that the inpatient care furnished in the primary care facility from October 25 through October 31, 1977 "meets the regulation requirement for medically necessary care provided at the appropriate level for the services and is a CHAMPUS benefit." That decision concluded that benefits were not available for the care provided from November 1, 1977 through March 22, 1978.

The sponsor contends that the entire extended care period should be covered. OCHAMPUS maintains first, that benefits may not be extended through March 22, 1978, and second, that the additional six days of inpatient stay acceptable to the peer reviewer and paid previously on that basis, is in excess of the CHAMPUS norm of 21 days of inpatient care, is not based on medical necessity, and accordingly that benefits should be denied for coverage from October 25 through October 31, 1977 with funds previously disbursed for that period being subject to recoupment.

The ruling in the Formal Review Decision has the effect of allowing the maximum seven days discussed by Dr. Mintz in addition to the basic 21 days described in the CHAMPUS regulation as the usual period of care. The issuer of the Formal Review Decision thus understood Dr. Mintz's allowance of the additional three to seven days as being medically necessary at the appropriate level of care. This is surely how he intended to regard the excess he allowed, although there is some lack of clarity in the paragraph in which he did so. The OCHAMPUS Statement of Position filed with the Hearing Officer in this appeal relies on that ambiguity to suggest that only the initial 21 days, plus a day of detoxification, are medically necessary/appropraite care.

In the opinion of the Hearing Officer, the intention of Dr. Mintz was to apply the medical necessity/appropriate care talisman, based on the patient's psychological condition to the entire period of (1) one day

detoxification observation, plus (2) 21 days of rehabilitation plus (3) an additional "three to seven additional days." This is how the Deputy

Director, as reviewer of the file at the Formal Review Decision level , understood the opinion of Dr. Mintz. That opinion allowed some leeway as between the 25th and 29th day, and discretion was exercised by the Deputy Director in the manner most favorable to the claimant,by allowing a total of 29 days. In the opinion of the Hearing Officer the present OCHAMPUS position seeking to dig in and make a stand at the 21-day cut off point is not persuasive.

The sponsor contends that the patient needed extended care treatment because of the severity of her condition as indicated by its chronic nature, by the abuse of medications as well as alcohol, by the suicidal attempts or gestures, by the absence of halfway houses or other treatment centers available, by the success reported in other four to six month programs, and by the apparent success of this treatment. He argues that one extended care treatment is more cost-effective than repeated 21-day treatments.

The sponsor is supported by the opinion of Robert H. Pogue, M.D. who supports the use of extended care treatment for this patient, as follows:

> I have known for over two years now and, of course, am aware that her treatment was extremely successful. The treatment of addiction requires more than a 28-day program in many instances including my own and I see nothing unusual or out of the way in the patient's being treated for this length of time. Presently the physician's program in Atlanta has a standard and routine four-month treatment program that is often extended beyond this for physicians. , of course, is an extremely well-educated, very complex patient who has in advanced stages of her addiction at the time of treatment and required the structure and constraint reinforcement of an inpatient setting. Hazelden, of course, is a leader in the treatment of addiction and had she not required this kind of treatment, it certainly would not have been offered or recommended to her at that time.

The sponsor's contentions that the tragic five-year history of this patient's drug and alcohol abuse makes this case such an exceptional case that an additional five and one-half months for inpatient rehabilitation treatment must be approved as CHAMPUS benefits falls short of establishing that CHAMPUS benefits are available under the law for such treatment. This is not to say that the services were not useful to the patient. No doubt they were. Her subsequent history of good adjustment and no recidivism attest to that. There is a difference, however, between a useful service and being a service for which CHAMPUS benefits are available.

The dispositive regulation from chapter IV.E.4. has been addressed on appeal at the ASD(HA) level in, for example, a Final Decision in a case numbered OASD(HA) File 80-04. That decision supports the foregoing analysis as follows:

> Therefore, under CHAMPUS, coverage of inpatient treatment of alcoholism consists of a detoxification phase of from three to seven days followed by a rehabilitation phase. The combined program will not normally be approved for more than a maximum of three weeks per episode. The alcoholism provision specifically notes inpatient care for alcoholism during acute periods is considered reasonable and medically necessary because of the ". . . probability that medical complications will occur during alcohol withdrawal necessitating the constant availability of physicians and/or complex medical equipment . . ." (emphasis supplied). Inpatient care may continue into the rehabilitative phase; however, as this office has determined in a prior FINAL DECISION (OSAD(HA) 02-80), it is the presence of severe medical effects of alcohol that qualify the rehabilitative phase to be conducted on an inpatient basis. Therefore, to extend CHAMPUS coverage for inpatient care beyond twenty-one days, the specified Regulation norm, the hospitalization must be necessary for treatment of medical complications associated with alcohol withdrawal.

It is the conclusion of the Hearing Officer that the instant case, while it presents compelling evidence of serious psychological, emotional and addiction problems, does not present such medical complications as are stated in the regulation as interpreted at the ASD(HA) level as illustrated by that decision. Issues involving whether the regulation and its application are arbitrary and capricious, and procedural matters particular to this case, are discussed under various subject headings hereinafter.

SECONDARY ISSUES

1. Medical Necessity and Law of Medicaid and Insurance Contracts

The sponsor contends that medical necessity must be found, as a matter of law, and has moved for summary judgment in accordance with that theory. The basis for that motion is the contention that the good faith judgment of a treating physician as to the necessity for hospitalization establishes medical necessity without further inquiry.

The sponsor cites as authority for such a position certain decisions of state and U.S. District Courts arising from various controversies involving interpretations of insurance contracts and one case involving a denial of medicaid benefits. The Medicaid case, Granville House v. HHS, 550 F. Supp. 628 (1982) in the U.S. District Court in Minnesota, involved denial of benefits for alcohol rehabilitation treatment pursuant to classification of chemical dependency as a mental illness which is excluded from medicaid rather than a medical condition eligible for benefits. The case dealt with the question of whether classification of chemical dependency as a mental disorder for purposes of its presentation in the Diagnostic and Statistical Manual prepared by the American Psychiatraic Association should justify the denial of medicaid benefits when alcohol dependency has been classified as a physical illness by the American Medical Association since 1957. It was held that it does not. This case, however, sheds no real light

on the legal significance of the term medical necessity as used in the CHAMPUS regulations.

The cases involving insurance benefits, frequently under Blue Cross contracts, and primarily the case of Mary Van Vactor v. Blue Cross, 50 Ill. App. 3d 709, 365 N.E. 2d 638 (1977), and the similar cases cited, dealt primarily with placing the burden of proof as to whether a condition fell within an exclusion on an insurer, consistent with standard case law precepts holding that any ambiguity in insurance contract provisions will be resolved in favor of the insured and against the insurer. In a nutshell, the issue before the Court was whether, as a matter of contract, the brochure provided to the policyholders contains language sufficient on which to justify a denial of benefits based on a unilateral, after the fact, review of the facts in a particular claim and disagreement with the good faith judgment of the treating physician.

The Court held that the brochure, which sets forth an exclusion from coverage which reads "not medically necessary for the diagnosis or treatment of an illness, injury or bodily malfunction . . ." is not sufficient to put the insured on notice that he cannot rely on the judgment of the treating physician in obtaining coverage thereafter. The effect was to base payment of benefits on the judgment of the treating physician.

This decision of the appellate court of Illinois, interpreting an insurance contract, thus held that an insurer could not deny hospitalization benefits solely because it disagreed with the good faith judgment of a treating physician as to the necessity for hospitalization. The insurance contract under consideration, like the CHAMPUS regulation, excludes coverage for services and supplies "not medically necessary for the diagnosis or treatment of an illness, injury or bodily malfunction . . ." In this case, which was a class action of 3,590 claims, Blue Cross had ruled that the hospital records did not support the need of an inpatient setting for removal of impacted teeth. The Court ruled that this was a matter of contract interpretation, that there was an ambiguity in the contract as to whether there was to be review by the insurer on the issue of medical necessity of the treatment or simply to determine whether the services rendered met the specific conditions and exclusions set out as such in other sections of the contract. The Court concluded that these provisions created an ambiguity which must be resolved in favor of the insured.

The case of Haggard v.Blue Cross, heard in the Alabama Court of Civil Appeals in 1980, followed the Van Vactor case and concluded that the term medically necessary is broad, ambiguous and susceptible to various meanings; and it therefore must be construed in the fashion most favorable to the insured.

The case of Aetna Life Insurance Company v. Martin, decided in the Alabama Court of Civil Appeals in 1980, involved a claim for medical expenses incurred by the insured's wife for augmentative mamoplasty to procedure bilateral symmetry. The Court concluded that while reduction would be covered, enlargement would come within the terms of

the policy exclusion clause because it did not improve the woman's bodily functions but was merely a cosmetic operation.

The case of Gunther v. Blue Cross, heard in the North Carolina Court of Appeals in 1982, dealt with a claim under a health insurance contract for the expenses of hospitalization of the insured's son for mental illness. The trial court found, and the appellate court upheld, that the controverted expenses did not come within the exclusion language of medical necessity. The Court held that the defendant insurer had the burden of proving that the controverted expenses came within the stated exception of the policy and had not done so.

The case of Majors v. Blue Cross, decided in the Louisiana Court of Appeals in 1981, involved a denial of a claim for three hospitalizations on the grounds of medical necessity, the trial court found they were medically necessary and the appellate court upheld that decision.

In determining whether these cases apply here, first it is noted that the sponsor is correct that the OCHAMPUS medical necessity exclusion is virtually identical to that found in the Blue Cross contracts considered in these cases. Second, OCHAMPUS conceded that the treating physician can define what is medically necessary under a contractual health benefits program but contends that the cases cited do not apply to the CHAMPUS program which is a statutory health benefits program. In comparison, the CFR Sections provided by the sponsor, and specifically 32 CFR 199.10(d)(4) discussing inpatient stays during a rehabilitative program states specifically that: "Each such case will be reviewed on its own merits to determine whether an inpatient setting continues to be required." The cases are based on standard legal procedures for construing ambiguous contracts, and focus on whether there was a reasonable notice of the contract details to the insured.

The foregoing language makes it abundantly clear under the applicable law that a review of such a case on a medical necessity basis will take place regardless of the actions or opinions of a treating physician. The CFR Section provides such notice. There is no reason to construe anything in order to determine whether a beneficiary had notice of the details. In any event, the Hearing Officer concludes that the CFR Sections are not a contract of insurance to be construed against the insurer; therefore, neither the holding nor the logic of the Mary Van Vactor case and similar cases is applicable. No other showing has been made by the sponsor sufficient to justify a conclusion that peer review per se is in excess of powers conferred to OCHAMPUS under the CHAMPUS Regulation or is forbidden by any other applicable federal law. Peer review has been adopted by the Director of OCHAMPUS as one of the means of conducting case reviews and the procedure has been endorsed both explicitly and implicitly in various Final Decisions which have been issued at the ASD(HA) level, such as, again, Case Number ASD(HA) 80-04.

The Hearing Officer therefore concludes as follows: (1) that peer review is an acceptable procedure to use as one means of obtaining expert opinions upon which to rely in reaching a decision, and (2) whether a service is medically necessary and at the appropriate level of care may be reviewed after the fact by the peer reviewer and by OCHAMPUS, as well as by a duly commissioned hearing officer,

notwithstanding a decision might be reached contrary to an opinion held by a treating physician. Accordingly, it was and is appropriate in this case to review the care provided to this patient as to what the facts show as far as the issues of medical necessity and appropriate level of care.

2. Peer Review - Admissibility and Reliability

At the hearing and in subsequent correspondence the sponsor moved that the peer review opinion prepared in this case by Dr. Donald Mintz be excluded or stricken from the record, asserting as grounds for that motion various objections to use of that peer review in reaching a determination in this case. The various grounds will be dealt with separately in the following paragraphs.

(a) Qualification of Witness

Section F.16.d of Chapter X of the Hearing Officer's Handbook issued by OCHAMPUS dated 3 March 1978 and in effect at the time of this hearing provides the following:

> Relevant Evidence. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions.

The biographical data provided for Dr. Mintz as found in Exhibit 29, p. 5 of 5, together with the detailed discussion of the responses in the peer review report itself, together with the answers to interrogatories, amply document that the opinions of Dr. Mintz would be "the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The record documents that his opinions would be admissible under the expert opinion rule applicable in most judicial jurisdictions in this country. Whether there are any special CHAMPUS regulations which render his report otherwise inappropriate for consideration in this care are discussed under other appropriate categories hereinafter.

(b) Right of Cross-Examination

The sponsor moved that he be allowed to submit interrogatories to Dr. Mintz and file the answers in this case. The relevant procedural regulation, Section F.16.e. of Chapter X ofthe Hearing Officer's Handbook provides the following:

> Interrogatories and Deposition. A Hearing Officer may order the taking of interrogatories and depositions (recognizing that the Department of Defense does not have subpoena power), and assess the expense to the requesting party when the Hearing Officer deems it proper.

Based on the foregoing regulation, the Hearing Officer ordered the submission of interrogatories to the peer review physician in this

case. It is concluded that the sponsor's right of cross-examination was thereby respected and satisfied.

(c) Review on Medical Records Only

The sponsor contended that posing of review questions in the form utilized, with a review "of the medical records five years after the fact" (Tr. p. 91), with no personal contact by the peer reviewer with either the patient or the sponsor, invalidates the peer review report. This is how peer reviews are done, however, and no basis has been shown upon which it might be concluded that the foregoing characteristics of the peer review are in themselves defects. Despite the existence of the peer review program, the appealing party has the right to obtain expert opinions from his witnesses.

The sponsor also contended at the hearing that the statement of facts presented to Dr. Mintz were necessarily deficient because they did not include the history developed by the sponsor at the hearing involving (1) the patient's failure to resolve her problem despite four previous programs of inpatient detoxification and outpatient treatment, (2) suicidal and homicidal threats and gestures, (3) abuse of alcohol treatment medications as well as alcohol itself, (4) lack of availability of halfway houses and effective outpatient programs in the area of the patient's residence. A significant portion of the information about previous hospitalization was, however, in the record prior to hearing, such as the history contained in Exhibit 27. The sponsor was able to present additional facts to the peer reviewer in the interrogatories, however, with the result that Dr. Mintz stated his opinion that these facts would not change his opinion previously expressed. (Interrogatories 441 through 45 and answers, Exhibits, 75) The Hearing Officer is satisfied that the peer reviewer had an opportunity to base his opinions, as amplified in the answers to interrogatories, on a full and adequate knowledge of the facts of the case.

(d) Peer Reviewer Regionalism

The sponsor contends that there is a specific guideline requiring that peer reviewers be selected from the region in which the case is rendered. The questions posed to peer reviewers usually involve questions of "medical necessity" and its subsidiary concept "appropriate medical care." The relevant regulation, Chapter II B.14.a., in defining "appropriate medical care" refers to medical services "in keeping with the generally acceptable norm for medical practice in the United States;" . . . Local or regional care is not an issue.

The sponsor contends, however, that the CHAMPUS Manual 6475.1-M, entitled "CHAMPUS Manual for Inpatient and Outpatient Psychiatric Claims Review," requires regional peer reviewers. Chapter IV of that Manual, entitled Peer Review Referral Procedures, provides in paragraph A.5 the following: "Each fiscal intermediary will be provided a list of psychiatrists from the geographic areas for which they process claims. When the decision is made to request peer review, three psychiatrists will be selected from the list." This Manual provision is

of limited effect: It sets forth the procedure to be utilized by the fiscal intermediaries in soliciting peer review opinions. In the case at hand, the peer review opinion was not solicited directly from OCHAMPUS by way of the APA Peer Review Project. This was explained in the record as having been done because the reconsideration review was being handled directly by OCHAMPUS.

In the Manual, following close after the quoted language, appears the facsimile of forms utilized by the fiscal intermediaries to solicit peer review opinions. Those were not used in this case and the peer review opinion itself was much more comprehensive and explanatory than would have been available if this opinion had been solicited by a fiscal intermediary using the standard form. There does not appear to be any requirement that OCHAMPUS solicit multiple opinions, and again this may well be related to the more thorough and analytical type of opinion which is provided directly to OCHAMPUS by the APA Peer Review Project than the abbreviated opinions provided to the fiscal intermediaries when solicited under the procedures described in the manual. The regulation and Manual do not appear to indicate any impropriety in considering a peer review opinion on Minnesota treatment by a California physician provided in response to a direct request from OCHAMPUS to the APA coordinator.

3. Absence of Alcoholism Guidelines

The sponsor contends that the peer review is defective for failure to provide the peer reviewer with guidelines and criteria. The sponsor cites Chapter IV.E.d. which provides the following:

> Review Guidelines and Criteria. The Director, OCHAMPUS or a designee, will issue specific instructions, guidelines and criteria for review for claims for services and supplies related to alcoholism.

The sponsor contends that the materials designated as Exhibit 90 constitute the only materials in the nature of guidelines found in the OCHAMPUS files. This assertion appears to be accurate based on the letter of transmittal from Fred E. Manner, Freedom of Information Act Officer, OCHAMPUS, dated December 10, 1982. It does not appear that these materials are regarded by OCHAMPUS as being the guidelines mentioned in the regulation. It appears from the statements of OCHAMPUS counsel that the only such guidelines and criteria promulgated to date are those which appear in the January, 1980 CHAMPUS Manual for Inpatient and Outpatient Psychiatric Claims Review, 6475.1-M at page B-7, dealing with symptomatology, physical findings, and treatment programs, including detoxification and rehabilitation, as well as outpatient treatment. This contains the criteria referred to in the OCHAMPUS Rebuttal Memorandum. The inpatient treatment section of that Manual states the following:

> Treatment program. Detoxification is usually done in a hospital that provides a supportive environment. Treatment usually includes psychotropic medications such as Librium in doses tailored to meet the patient's needs for sedation and

> relief of anxiety. The dosage is usually lowered and discontinued as detoxification is completed. Supportive psychotherapy and milieu therapy are usually needed and are provided within the limits of the patient's ability to tolerate them. The CHAMPUS Regulation states that detoxification without serious complications should not go beyond seven (7) days; a program that includes detoxification and rehabilitation usually requires about 21 days.

The foregoing section is consistent with Chapter IV.E.4.b. in providing the published OCHAMPUS standard of 21 days which has governed the OCHAMPUS position as to benefits in this case. The peer reviewer approved another "3 to 7 additional days" consistent with the usual 25-day period indicated by his experience and survey (Ex. 29, p. 2 of 5) and allowing a little extra for this particular patient's response having been "a bit slow regarding behavorial change." (Ex. 29, p. 3 of 5) There is no showing which is supported by the record indicating that the peer review findings were affected in any way prejudicial to the sponsor by the failure of OCHAMPUS to promulgate any additional guidelines or to transmit any guidelines to the peer reviewer.

4. 21-Day Norm: Arbitrary and Capricious?

The sponsor contends that the 21-day norm for inpatient treatment which is contained in the OCHAMPUS regulation is arbitrary and capricious. In support of this contention, he asserts Army Regulation 600-385, paragraphs 4-5B(3) and 4-6f providing for six to eight weeks of inpatient care for servicemen in military facilities, to be extended for such time as the treating physician deems necessary based on the physical condition of the patient or the history of failure of treatment. The sponsor also cites examples of other extended care programs which are available in various states. The sponsor contends also that the only information contained in the OCHAMPUS files, as appears from the Freedom of Information Act response (Ex. 90) consists of a committee recommendation as follows:

> Committee recommends a maximum 28-day hospital stay (in addition to seven days for detoxification) as an acceptable allowance for rehabilitation. The Committee suggests that a lower-cost residential facility be used whenever patients need additional care. An exception would be a unique individual case.

This Committee report is undated and is not identified further in this record. The record does not show any background data for the adoption of the 21-day norm.

The issue is whether a 21-day norm is arbitrary and capricious. The evidence is abundant that various inpatient alcohol rehabilitation programs often use 25 days, 28 days, 21 days (Ex. 9, p. 25), 31 days (Ex. 47, p. 4), or 21 days (Ex. 75, Mintz answers to interrogatories, A-7 and A-9), after three or four days for detoxification, for an overall stay of 25 days. These provide useful parameters for judging the reasonableness of a 21-day norm.

The initial 21-day period for detoxification and rehabilitation allowed by the CHAMPUS regulation appears well within the ballpark as "in keeeping with the generally acceptable norm for medical practice in the United States." Even in Minnesota, at this particular rehabilitation center, Hazelden, of 1,537 patients discharged from the primary treatment, "that the average length of stay for people completing treatment was 31 days. (Ex. 47. p. 4) In a case in which the sponsor is contending for five and one-half months, the difference between 31 days and 21 days as a normative period is not significant.

The CHAMPUS regulation does not provide for extended care except as a rare circumstance based on medical complications. It can hardly be concluded that the failure of the OCHAMPUS regulation to provide for extended care treatment on an inpatient basis is arbitrary and capricious when the sponsor's Exhibit 43, a comparison of inpatient and outpatient programs published in 1981, concludes that"inpatients and outpatients report almost identical outcomes one year after treatment." (Ex. 43, p. 18)

5. Procurement of Additional Medical Records

(a) From the Facility

The sponsor early in his presentation contended that on two occasions in the review process, including the second reconsideration, the file was closed by OCHAMPUS on the basis that the sponsor had not provided documents within his possession, which were medical record documents from the treating facility (Tr. p. 107) which OCHAMPUS had the right to obtain, whereas he was having difficulty obtaining them. Inasmuch as the various records have in fact been obtained and have been made a part of the record herein, the Hearing Officer does not presently perceive that the sponsor is presently relying on any issues arising from that earlier procedural impasse. There was an earlier suggestion made by the sponsor to the effect that the Administrative Procedure Act or case law provided for the payment of interest by the government to the claimant in connection with the sponsor's position on this secondary issue. In any event, the applicable OCHAMPUS procedural regulations provide no basis for an award of interest for or against any party by this Hearing Officer. Further, no additional showing has been made by the sponsor documenting a right to any such interest, and the issue is deemed abandoned, based on paragraph (h) of the sponsor's Response to the OCHAMPUS Rebuttal Memorandum. (Ex. 88)

(b) From Other Hospitals

The sponsor has also contended (1) that additional records should have been obtained by OCHAMPUS from the Surgeon General of the Army relating to the patient's prior medical history as taken by various army medical facilities in Germany, Kentucky and a civilian hospital in Louisville, Kentucky. As regards the availability of military records, the OCHAMPUS position is that the right of OCHAMPUS to receive medical information from a provider of services or supplies arises solely from the specific release which appears on the CHAMPUS claim forms. In the Rebuttal Memorandum prepared by OCHAMPUS counsel in this case, it is

stated as follows: "Although CHAMPUS has the right to obtain medical information from providers on CHAMPUS claims, this right does not extend to medical records for medical services provided by military doctors and hospitals." Nothing has been shown by the sponsor to the contrary and the Hearing Officer finds that OCHAMPUS does, in fact, have limited access to military medical records.

It is further contended by OCHAMPUS that OCHAMPUS has no obligation to attempt to obtain medical records, whether from military providers or from civilian providers, because "the responsibility of protecting CHAMPUS rests with the beneficiary or the provider acting on behalf of the beneficiary." (Para. 3., chapter VII, DoD 6010.8-R.) The gravamen of this position is that the right to obtain records from civilian providers does not constitute a responsibility for OCHAMPUS to obtain such records. The relevant procedural rules support such a position, as is provided in the March, 1978 CHAMPUS Hearing Officer's Handbook, Chapter X, S.11, Witnesses and Evidence, Para. F.16.i., Relevant Evidence, and Para. F.16.i., Burden of Evidence, those Manual provisions in turn being statutory provisions in CFR Title 32, Sec. 199.16 effective as a Department of Defense Issuance on January 10, 1977, including subparagraph (11)(iii), Burden of Proof. The latter provides as follows: "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 . . . .

This issue is, however, of no present consequence. By means of his testimony the sponsor was able to portray, in detail sufficient for consideration in this case, the patient's relevant medical history prior to her admission in 1977. By means of the interrogatories he was able to elicit an opinion from the peer reviewer based on the additional medical background information (see interrogatories 41 through 43, Ex. 75, and answers thereto).

Further the sponsor has not shown that any particular additional medical history which is not part of this record needs to be part of this record or that he has been prevented from obtaining any specific records which he feels necessary as a result of any regulations or actions of OCHAMPUS, except as related to the requested records regarding CHAMPUS payments for extended care for allegedly similar patients at this particular facility, which is discussed hereinafter.

(c) Denial of Access to Medical Records in Allegedly Similar Cases

The sponsor contends that claims have been paid to this particular facility for extended care in circumstances similar to this case. It is the position of the sponsor that OCHAMPUS should release or provide such records to the sponsor, or allow the rehabilitation facility to reveal such claim patient information to the sponsor, or at least that OCHAMPUS should confirm or allow the facility to confirm that two such cases have been paid. (Tr. p. 114) OCHAMPUS counsel has objected to an inquiry as to that information on the grounds of relevance. The sponsor contends that 32 CFR 199.13(b)(4), Right to Additional Information, provides a basis for the procurement of such records by OCHAMPUS. This provision relates to providers furnishing services or

supplies to a beneficiary and making a claim for benefits. 32 CFR 199.10(a)(5) has virtually identical language and purport. 32 CFR 66.3 provides for release of medical information concerning a patient under the CHAMPUS benefits program.

The findings of the Hearing Officer on this latter secondary issue of allegedly similar patients are as follows: (1) that the sponsor does not have access to the requested information, because of lack of authorization and the denial of access of the facility, (2) that he does not know for a fact whether the asserted cases are identical, (3) that OCHAMPUS objects to ascertaining information about any such cases on the grounds that it would not be relevant. It is obvious that OCHAMPUS would take the position, if the information were obtained and showed that such claims had been paid by the fiscal intermediary, that the payment was made in error and would not constitute precedent for making a payment in error in this case, but rather that OCHAMPUS should undertake recoupement procedures in those cases. (Tr. p. 114) Therefore, even if we assume for purposes of this case that production of such records would produce the information suggested by the sponsor, it would not be relevant to a determination of this case. It follows that if the records themselves would not be relevant, the sponsor is not prejudiced by his inability to obtain them.

6. Ex Parte Communication

The sponsor contends (Ex. 88, p. 1) that the OCHAMPUS Rebuttal Memorandum (Ex. 80) was apparently not sent to him in a timely fashion and constitutes an ex parte communication. Actually, the memorandum was discussed at the hearing when all parties were present, and was the subject of correspondence to and among all parties, and its eventual filing with the Hearing Officer was expected. There has been an intermittent but substantial filing of materials by both parties with the Hearing Officer throughout the approximately one and one-half years that this case has been before the Hearing Officer, and the Hearing Officer notes that these filings have been characterized by timely copies to other parties consistent with a spirit of full and fair notification to adverse parties expected under normal adjudicative proceedings. No showing has been made for this record regarding the apparent failure to timely serve the Rebuttal Memorandum. In the context of the usual courtesies extended between counsel in this case, however, the Hearing Officer will indulge the assumption that it was an oversight. No showing has been made that it was done in bad faith.

Furthermore, in view of the ultimate receipt of it by the sponsor, the Hearing Officer finds that no prejudice was occasioned thereby. Since the OCHAMPUS Rebuttal Memorandum primarily responded to issues raised by the sponsor and did not significantly raise new factual matters, and since the claimant in fact responded to it, the Hearing Officer concludes that the sponsor was not prejudiced by the apparent delay in its forwarding to him.

The Appendix I to Exhibit 82, Dr. Mintz's Curriculum Vitae, was ultimately filed with the Hearing Officer and after its omission was complained of by the sponsor in Exhibit 88, and presumably served on the sponsor. It was made a part of the record as Exhibit 94, but was not

relied upon by the Hearing Officer. Again, no prejudice to the sponsor appears as regards the timeliness of its delivery.

7. Request for Specific Findings

The sponsor has requested specific findings (Ex. 89) which are essentially ultimate conclusions (1) consistent with the Van Vactor case or (2) consistent with rejection of the peer review opinion; based on other analysis herein those proposed Findings numbered 1 through 8 are expressly not found as facts or conclusions on which this Recommended Decision relies.

8. CHAMPUS Payment at a Lower Level of Care

In its Rebuttal Memorandum OCHAMPUS contends that CHAMPUS benefits are not available for payment at a lower level of care because "the appealing party has not submitted a claim to cost-share expenses at a lower level of care." (Ex. 80) The sponsor's response to this is that "the claim has been presented in excruciating detail." (Ex. 88, p.19) It appears to the Hearing Officer that there is no claim pending for payment of benefits which might be available based on a lower level of care, and if there is such a claim implicit in the existing claim, which OCHAMPUS denies as a matter of law, then the sponsor has failed to carry the burden of proving such a claim.

9. Assessment of Expenses

The procedural history of this appeals case has raised the question of interrogatories and the assessment of the expense associated therewith. Based on Section 16.e. of Chapter X of the Hearing Officer's Handbook, the Hearing Officer may "assess the expense to the requesting party when the Hearing Officer deems it proper." The interrogatories for Dr. Mintz were filed with the Hearing Officer and referred by the Hearing Officer to the Officer of Appeals and Hearings (Ex. 57, p. 3 of 3) with the following statement as to the assessment of expenses: "I am withholding determination of the assessment of the expense of taking these interrogatories until such time as I ultimately issue my decision on the merits."

The sponsor also sought answers to certain interrogatories from his witness, Dr. Pogue. In ruling that the record could be reopened for an exhibit reflecting Dr. Pogue's answers to interrogatories, the Hearing Officer ruled that Dr. Pogue should provide answers to an appropriate selection of those same interrogatories, and ordered that the expenses of answering such interrogatories would be assessed to the claimant (Ex. 57, p. 2 of 3) and with reference to any additional interrogatories which OCHAMPUS might wish to propound to Dr. Pogue, the Hearing Officer stated that: "It is my intention to reserve the determination of the assessment of costs until the date of issuing my decision." No such statement of interrogatories or answers thereto were filed, and no answers were filed showing Dr. Pogue's response to the original interrogatories. No statement of costs has been filed with the Hearing Officer or with OCHAMPUS in connection with services by Dr. Pogue so that is concluded to be a matter between the sponsor and Dr. Pogue which requires no further consideration herein.

The sponsor subsequently propounded supplemental interrogatories to Dr. Mintz. (Ex. 67) The Hearing Officer assessed the expenses of answering those supplemental interrogatories against the sponsor. (Ex. 71) This expense has apparently never been paid by the sponsor, and it was agreed upon by the parties that those supplemental interrogatories and the answers thereto would be stricken from the record rather than delaying the issuance of a Recommended Decision indefinitely awaiting the resolution of the apparent expense payment impasse. Accordingly, Exhibits 67 and 76 were excluded from consideration herein.

The only remaining matter for resolution with reference to the assessment of costs in connection with the use of interrogatories and their answers in this case is, thus, the answering of the original interrogatories by Dr.Mintz, as contained in Exhibit 67. No statement of these expenses, as distinguished from the expenses associated with the supplemental interrogatories, has been filed with the Hearing Officer. In any event, the Hearing Officer concludes that the sponsor had a right under the applicable procedural regulation to obtain answers to the original interrogatories as a reasonable form of cross-examination of the peer reviewer, and that it would not be proper to assess such expenses against the sponsor in this case.

SUMMARY

In summary, it is the Recommended Decision of the Hearing Officer that the inpatient care provided to this beneficiary from November 1, 1977 to March 22, 1978, must be denied CHAMPUS cost-sharing because it represents alcohol and chemical dependency rehabilitation treatment not provided coverage by the CHAMPUS regulation; the inpatient rehabilitation treatment offered between October 3 and October 24, 1977, is within the normative period of rehabilitation care provided by the regulation, and the inpatient treatment given between October 25 and October 31, 1977, is within the parameters of extension of care in a particular case based on peer review concurrence. It is thus the Recommended Decision of the Hearing Officer to uphold the Formal Review Decision.

William E. Anderson
CHAMPUS Hearing Officer