



ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of)	
)	
Sponsor:)	OASD(HA) Case File 85-19
)	FINAL DECISION
SSN:)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-19 pursuant to 10 U.S.C. 1071-1092, and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary, the dependent son of an active duty officer of the United States Navy. The beneficiary was represented by his father at the hearing. The appeal involves the denial of CHAMPUS cost-sharing for residential treatment at the Devereux Foundation in Santa Barbara, California from June 16, 1984, through the date of the appeal hearing, October 10, 1984. The amount in dispute is approximately \$11,200.00 for care provided after June 16, 1984, through the hearing date. Additional amounts also have been placed in dispute as a result of the hearing process. These relate to educational charges of approximately \$775 per month which apparently have been billed to and paid for in part by the fiscal intermediary and in part by the involved school district during the beneficiary's stay at the residential treatment center.

The hearing file of record, the Analysis and Recommendation of the Director, OCHAMPUS, and the Hearing Officer's Recommended Decision have been reviewed. It is the Hearing Officer's recommendation "that benefits at the Devereux Foundation - California Residential Treatment Center be approved for this beneficiary as authorized from February 21, 1983, through June 15, 1984, but authorization for benefits after that date be denied as an important therapeutic issue has not been addressed as is required for appropriate, medically necessary care under the CHAMPUS Law and Regulation." This recommendation is based upon a finding that the treatment plan provided for the beneficiary did not adequately involve the family in the therapy and thus did not meet the standard of care in treating children and adolescents in the United States. It is further the recommendation of the Hearing Officer "that during the period when RTC benefits are authorized, the identified educational cost of \$775.00 per month be deleted before CHAMPUS benefits are paid, as these educational costs are specifically excluded by CHAMPUS

Regulation." The Director, OCHAMPUS, concurs in the recommendations of the Hearing Officer.

The Assistant Secretary of Defense (Health Affairs) after due consideration of the appeal record, adopts and incorporates by reference the Hearing Officer's Recommended Decision to allow cost-sharing of the previously authorized RTC care from February 21, 1983, through June 15, 1984, to deny cost-sharing of RTC care provided after that date through the date of the hearing, and to deny cost-sharing of educational costs. This decision is based on my findings that the care provided to the beneficiary after June 15, 1984, was not medically necessary or appropriate because the facility failed to properly involve the family in the beneficiary's therapy (even after this therapeutic deficit was brought to their attention) and educational costs are excluded by regulation.

As the Hearing Officer noted in her Recommended Decision, this case was submitted to the American Psychiatric Association (APA) for peer review in connection with the initial request for approval of CHAMPUS benefits for residential care. It was the consensus of the three psychiatrists who reviewed the case that a residential treatment center would be an appropriate trial placement for this beneficiary. These opinions were in essential accord with the private practitioners who had been involved in the beneficiary's treatment prior to his admission to the residential treatment center. For example, a psychologist who had performed a psychological evaluation in December 1982, concluded that the beneficiary was functioning at the mildly retarded level with neurological impairment accounting for a great deal of the beneficiary's behavioral symptomatology. The psychologist recommended residential treatment if it addressed both his neurological and emotional handicaps.

I find that the medical professionals who reviewed this case prior to and at the time of the beneficiary's admission for residential treatment were in essential agreement that this form of therapy was appropriate on a trial basis; however, all had reservations concerning the ultimate propriety of this form of treatment for this beneficiary. Given the conditional nature of the admission for residential treatment, it was important and appropriate for OCHAMPUS to review the initial decision to admit the beneficiary for this placement after about one year of treatment. What was found as a result of this review was that the treatment plan was not appropriately addressing this beneficiary's neurological and psychological deficits. The Hearing Officer found, and I concur, that there is almost no documentation in the record of psychotherapy over an 18 month period. Further, as noted by the OCHAMPUS Medical Director, the record confirms that the facility's program was primarily oriented towards educational services for the beneficiary. While such services were a necessary part of this beneficiary's treatment milieu, I find that the record does not document sufficiently that the beneficiary's neurological and emotional disorders were adequately addressed in the treatment he received.

Accordingly I find that the overall medical environment provided to this beneficiary was not at a level adequate to provide the required medical care and that the services provided were not medically necessary under CHAMPUS.

This finding is broader than and in addition to the more specific finding of the Hearing Officer concerning the issue of family involvement in the therapy.

It is also important to note here that because the admission was initially made on a trial basis, OCHAMPUS acted properly in providing advance notice to the beneficiary and the facility of its finding that the treatment plan was inadequate in this regard. I concur with the Hearing Officer that this provided the facility with an opportunity to correct the deficiency, and that no such correction was forthcoming.

In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence including authoritative, medical opinions in this appeal. The findings are fully supported in the Recommended Decision and by the appeal record. Additional factual and regulatory analyses are not required. The Recommended Decision is acceptable for adoption in full by this office.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to cost-share the residential treatment provided to the beneficiary from February 21, 1983, through June 15, 1984, and to deny cost-sharing of that care from June 16, 1984, through October 10, 1984, the date of the hearing, because the provider failed to adequately address an important therapeutic issue of involvement of the family in therapy even after the deficit was brought to its attention. The residential treatment was, therefore, not medically necessary or appropriate under CHAMPUS. It is also my finding that the overall medical environment provided to this beneficiary was not at a level adequate to provide the required medical care and, therefore, the services were not medically necessary nor appropriate under CHAMPUS. Further, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that, during the period where RTC benefits are authorized, the identified educational costs of \$775.00 per month be deleted from CHAMPUS cost-sharing as these costs are specifically excluded as benefits of CHAMPUS and should have been billed to the local school district. The record indicates that although the school district was billed, the amount billed represented only the patient's cost-share (approximately \$6.55 per day) for inpatient care. After billing the school district for the beneficiary's educational costs, the facility should be aware of its obligations to collect any unpaid portion of the beneficiary's cost-share.

The record indicates that the beneficiary continued in the RTC for an undetermined period after the date of the hearing.

The record is devoid of evidence concerning the condition of the beneficiary or the treatment plan prescribed for him by the facility staff. For this reason, this FINAL DECISION cannot finally resolve any issues raised by the subsequent care. However, as this FINAL DECISION denies cost-sharing because of the lack of family involvement in the treatment, to the extent the treatment subsequent to October 10, 1984, does not include family involvement consistent with this FINAL DECISION, claims for care after October 10, 1984, are to be denied cost-sharing. Finally, the appealing party will be afforded an opportunity to submit claims not previously submitted for care provided to the beneficiary through June 15, 1984. The CHAMPUS fiscal intermediary shall also conduct an administrative review of the claims payment history and make any necessary adjustments required as a result of this FINAL DECISION, including the deletion of educational costs from any claims previously paid. Any recoupment action required as a result of the review of the claim payment history will be considered under the Federal Claims Collection Act. Issuance of this FINAL DECISION completes the administrative appeal process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

William Mayer, M.D.
William E. Mayer, M.D.

RECOMMENDED HEARING DECISION

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

Beneficiary:

Sponsor:

Sponsor's SSN:

This is the recommended decision of CHAMPUS Hearing Officer Hanna M. Warren in the CHAMPUS appeal of

., and is authorized pursuant to 10 U.S.C. 1071-1089 and Regulation DoD 6010.8-R, Chapter X. The appealing party is the beneficiary's father, an active duty Navy Lt. Commander. The appeal involves the denial of CHAMPUS cost sharing for residential treatment at the Foundation in Santa Barbara, California, from June 16, 1984 through the present as I have been advised the beneficiary is still residing at the RTC and also whether CHAMPUS can cost-share the educational component of care. As of the date of the hearing no changes had been made in the treatment plan, but I do not know what has occurred since that date. The amount in dispute is approximately \$11,200.00 as of the date of the hearing for care after June 16, 1984. The charge per month as of September 1, 1984, is \$2,825 with the patient's share being \$207 per month (Exhibit 38). The educational charge is \$775 per month.

The hearing file of record has been reviewed along with the testimony at the hearing and the exhibits submitted since the hearing. It is the OCHAMPUS position that the formal review determination issued July 9, 1984, denying CHAMPUS cost sharing of the residential treatment center care provided to the beneficiary after June 15, 1984, be upheld on the basis that the care provided after that date was not medically necessary under the CHAMPUS Law and Regulation because it was not in keeping with the generally accepted norm for medical practice in the United States, and residential treatment therefore was above the appropriate level of care. It is also the OCHAMPUS position that the educational component of the charge during the entire period of residence has been improperly paid as it is excluded from coverage under the Regulation. The sponsor requested a hearing and a hearing was held on October 10, 1984, at the United States District Courthouse, San Francisco, California, before OCHAMPUS Hearing Officer Hanna M. Warren. Also in attendance were the sponsor and his wife, Ms.

Ms. , and , a CHAMPUS Hearing & Appeals Assistant, who attended as an observer. Ms. attended the hearing representing OCHAMPUS.

The Hearing Officer, after due consideration of the appeal record, concurs in the recommendation of OCHAMPUS to deny authorization for CHAMPUS cost sharing after June 15, 1984, and to deny coverage for the educational component during the period when care was authorized. The recommended decision of the Hearing Officer is therefore to deny cost sharing for the care received by the beneficiary at the Devereux Foundation-California after June 15, 1984 and to deny cost sharing of the educational component of care received from February 21, 1983, through June 15, 1984.

FACTUAL BACKGROUND

The beneficiary in this hearing was 14 years old when he was admitted to the Residential Treatment Center in Santa Barbara, California, on February 21, 1983. This followed a long history of seizures and multiple behavior problems. The patient was seen in a psychiatric evaluation prior to placement in the residential treatment center and this report (Exhibit 7) contains a description of the patient's past history, both medical and social, which is repeated many places in the record and confirmed by testimony at the hearing. It reports the patient was adopted at age 3 1/2 weeks and developed with milestones comparable to that of his siblings, being described as a "easy child" up until just under 1 year of age when the following occurred:

"On Thanksgiving Day, 1969, when was ten and one half months old, he had an episode of staring from which he could not be roused. His eyes were open, but he was unresponsive. On the way to the hospital, he had a generalized motor seizure. Upon arrival at the hospital, he was unresponsive and his eyes were closed. After observation, he was sent home and had another generalized seizure that same day. He was then taken to the hospital at Travis Air Force Base. At this time, he was noted to have a left sided hemipalegia, which took approximately six weeks to resolve. has had a seizure disorder, neurological deficits, and behavior problems since that time. It is unclear as to the etiology of the seizure. It is also unclear if the neurologic deficits are a result of the same cause as the seizure or (more likely) the result of anoxia caused by the seizures.

was placed on Phenobarbitol, which controlled his seizures but caused hyperactivity and crying spells. At age four and one half years, his mother discontinued the Phenobarbitol because of its behavioral effects and because seemed to be withdrawn in preschool. The discontinuation of the medication caused dramatic behavioral improvement,

especially increased socialization, but the seizures returned, precipitating at least one hospitalization during which he had seizures over a three hour period. At present, he has had no major motor seizures since 1975. He is on Valproic Acid 250 mg. (six per day) and Tegretol 200 mg. (four per day). In addition, he had been on Mellaril 10 mg. q.i.d. for his behavioral symptoms but this was discontinued by Dr.

during the course of this evaluation because of the tendency of the Mellaril to precipitate absence seizures. Reportedly, the number of absence seizures was increasing and their presence was noted by Dr. during testing of

had special help in the areas of speech and gross and fine motor movement at Mount Diablo Rehabilitation Center at the preschool level, and he began in their kindergarten at age 5 and one half years. Even in that special class, he was unable to maintain social relationships with the other children. He was in a special day class for multiply handicapped children at Shadelands School in first grade; he was transferred to Treat Learning Center from grade 2 until 1981. At that time, he began in the Comprehensive Education Program (C.E.P.). This examiner's experience with Treat Learning Center and C.E.P. is that they receive, primarily, children with a combination of learning and behavioral disorders. From this, I conclude that . 's behavior disorder was already quite severe by second grade and has been unremitting. On the other hand, the students in these programs tend to have acting-out disorders and with his neurologic handicaps and poor social skills, probably did not fit in with the other children, so school must have been a painful and, at times, frightening experience for him.

continued to receive tutoring in reading and math at Mount Diablo Rehabilitation Center until June 1981. Reportedly, his best academic year was his last year at Treat when he was given an instructional aide whose duties consisted of one-to-one tutoring with .

In the playroom, generally behaved in a way that would be considered more characteristic of an eight to ten year old child. His play had an impulsive and distractable quality; his persistence at any one task was quite low. There was evidence of visual motor incoordination. No overtly bizarre behavior was noted. He spoke in single sentences and was unable to amplify any statement, nor could he provide more information when requested to do so. He was alert and oriented to time, place, and person. Formal testing of memory was not attempted. Play was too disrupted by his distractibility for any major themes to emerge."

The psychiatrist during this evaluation gave a diagnosis of Mild Mental Retardation (DSM III 317.0) and Attention Deficit Disorder without Hyperactivity (DSM III 314.00). This was qualified by the following statement: "Such diagnosis do not, however, truly reflect the extent of his ego deficits. He presents a picture of the Borderline child as defined by Ekstein and by Pine; there is no comparable DSM III diagnosis and this is quite different from the DSM III definition of borderline personality. The rapid shifts in ego states seen at school, at home, and in Dr. Wulf's testing indicate that he has very poor and variable ego integration and could be expected to have brief periods of functioning at a psychotic level. There is little doubt that these difficulties are an outgrowth of his organic deficits" (Exhibit 7, page 3).

The recommendation was that the patient would benefit from intensive treatment in a residential treatment center and the program offered by the Devereux Foundation in Santa Barbara would be appropriate. The report concludes: "Anticipated length of stay in such a program would be approximately two years. Although his longterm prognosis must remain guarded, there is every reason to expect that he could eventually live and work in some type of semi-independent, sheltered situation. Without residential treatment, the prognosis is grave, especially in view of the fact that has yet to deal with the developmental tasks of adolescence" (Exhibit 7, page 4).

At the same time as the above psychiatric evaluation, a psychological evaluation was performed (Exhibit 6). The patient had previously been evaluated in March and October, 1981, and this evaluation was conducted in December, 1982. This evaluator stated: "Numerous previous evaluations have identified neurological and emotional handicaps of significant extent with little improvement over the years". She described the patient as extremely difficult to get to focus on a task, wandering, playing with objects in the room and exhibiting "rather bizarre behavior". The latter included "banging his head with Rorschach cards, facial grimacing, making odd grunts and noises, chewing on rubber darts, rubbing his nose on TAT cards, etc.". She also described a rather frequent behavior in which the patient would stare into space for numerous seconds and then start doing something other than the task at hand. She described these staring spells as "absences" and recommended that he be evaluated by a neurologist. Her conclusion was that the patient was "functioning in the mildly retarded range of intelligence, with a verbal IQ of 77, Performance IQ of 64, and Full Scale IQ of 69", which was approximately the same as the findings in the previous evaluations. She found that neurological impairment accounted for a great deal of the patient's behavioral symptomatology and certain difficulties suggested temporal lobe deficits. The summary as a result of the psychological testing was as follows:

" is functioning in the mildly retarded to borderline range of intelligence with significant and diffuse neurological deficits which impair both cognitive and behavioral functioning. While his behavior suggests severe emotional disturbances, testing suggests that the primary impairment is diffuse brain damage, which causes secondary (although significant) impairments in behavioral, interpersonal, and emotional functioning. Testing suggests neurological handicaps involving both left and right hemisphere functions, with frontal and temporal lobe functions being most significantly impaired. has difficulty with language abilities such as poor spelling and dyslexia (left hemisphere); with distractibility, impulsivity, and problems changing sets (frontal lobe); with visual-motor integration and non-verbal reasoning (right hemisphere); and with visual and auditory sequencing (temporal lobe). Testing suggests that right hemisphere and frontal lobe deficits may be more significant. These organic deficits can also be attributed to 's inability to modulate and label feelings, to his facial grimacing, and to his impulsivity. While his ability to perceive reality accurately appears unimpaired, it is likely that experiences the world as whirling by him very fast, and it is likely he understands less than fifty percent of what is actually going on around him" (Exhibit 6, page 4).

It was the recommendation of the psychologist that residential treatment would be appropriate for the patient if it addressed both his neurological and emotional handicaps. She also recommended that his parents accompany him for up to the first week of placement so he would feel some familiarity and continuity as he adjusted to new surroundings, otherwise she felt he might decompensate for a period of time.

Dr. had seen the beneficiary in outpatient psychotherapy commencing sometime at the end of 1979. In March, 1981, he wrote a letter describing the patient and his treatment as follows (Exhibit 10):

"The ongoing treatment plan speaks to a severe disorder, which is best described diagnostically as Psychosis Associated with Other (and unspecified) Cerebral Condition (293.9). The focus of this multi-faced intervention is individual therapy for with an emphasis on strengthening adaptive defenses and moving toward more flexible and functional cognitive styles when confronted with conflictual situations".

He anticipated at least one more year of outpatient once-a-week therapy, with the goal being to gain greater control of behav-

iors that are socially and personally maladaptive such as head banging and chest thumping. He concludes: "Finally, a portion of each session will involve contact with mother to process, clarify, and re-formulate parenting issues and styles".

The record shows that a IEP Team Meeting was held in October, 1982, to discuss this patient and his current placement within the school district. The report states: "A search of the surrounding area shows no public school that is able to meet s unique emotional and behavioral needs. Therefore, the team recommended non-public school placement in a comprehensive treatment facility." (Exhibit 15) It was the decision of this team that the school district program specialist would assist the parents to investigate treatment centers in California and a hearing would be held before the Board of Education to procure permission for placement in a non-public school.

A request for approval of CHAMPUS benefits for residential treatment care was submitted and, when all of the supporting information was received, it was submitted to the American Psychiatric Association CHAMPUS Peer Review Project for review and recommendation. Three psychiatrists reviewed the case and all three felt that a residential treatment center would be an appropriate trial placement for this patient. The first reviewer concluded that, due to a lack of response to outpatient treatment and medication management and the special education program in his community, RTC placement would be appropriate on a trial basis (Exhibit 20, page 1). This reviewer found the patient was not so retarded that he could not benefit from a therapy relationship and respond to a direct approach reality testing. He stated that custodial care could hopefully be avoided by an active individual treatment plan and that 2 years might be minimal if the patient could benefit. He recommended reviewing the progress of the patient at the end of summer, 1983. This reviewer noted that the available information was excellent regarding the psychological, neurological history and position, "but very little regarding family relationships, peer life, although family seems very interested".

The second reviewer had doubts about whether the patient had sufficient intellectual potential to respond to active psychiatric treatment but stated a "one to one educational approach could help" (Exhibit 20, page 4). His recommendation was residential treatment with a review approximately a year from the time of admission. The third reviewer felt concern in doing the evaluation because he did not have a treatment plan available, nor the qualifications of the staff. He did not recommend outpatient treatment, finding the record shows the patient "apparently requires more treatment than is available in the community" (Exhibit 20, page 7). He found the patient needed a particular type of therapy program whether inpatient, outpatient or RTC, but could make no recommendation regarding placement without a proposed treatment plan.

CHAMPUS cost sharing for residential treatment center care was apparently approved, although there is no record of this in the hearing file, and the patient was admitted to the Devereux Foundation in Santa Barbara on February 21, 1983. A treatment plan was submitted on April 18, 1983, after admission, (Exhibit 21) and the diagnosis was mild mental retardation (317), attention deficit without hyperactivity (314), partial complex seizure disorder with severe behavioral disturbances (Axis III. The treatment plan proposed one hour of individual psychotherapy per week, group psychotherapy as needed (daily), behavior modification as needed (daily), vocational therapy, which was to include prevocational training at a later date, psychoeducation (M-F, 8:45 to 2:55) and recreational therapy. The prognosis was partial remission of symptoms, with the patient expected to be discharged to his home, and an estimated length of stay of approximately 6 years. Section 7 of the OCHAMPUS Treatment Plan form requests information on family involvement and it is checked to involve mother and father at facility: "(1) Parent conferences semi-annually. (2) Written quarterly reports. (3) Weekly phone calls. (4) to visit parents for short periods during regularly scheduled vacations (e.g., Christmas, Easter, etc.)" (Exhibit 21, page 3).

A request for extension of authorization for residential treatment was requested in August, 1983, and a therapy report and school semester report was submitted along with a report to the parents which described his noncompliance with the staff and his problems with poor social skills (Exhibit 22, page 12). This report covers the first 12 weeks of care and makes no mention of any involvement with the family, nor family contact, except a therapeutic leave of absence from July 1 through July 6, 1983. The next progress report and request for extension of authorization for RTC care was dated November 3, 1983, (Exhibit 24). Again, the report describes his progress in behavior and social skills and contains the summer school progress report. The only reference to family in this report, other than to a summer vacation from August 18 to September 11, is in the therapy summary which states "parents remain involved through weekly phone calls, at least semi-annual parent conferences, etc. is non-compliant immediately prior and subsequent to home visits" (Exhibit 24, page 2). The therapist saw the beneficiary in individual therapy approximately 45 minutes a week and reported "our rapport remains fair to poor in terms of trust, spontaneity of verbalizations, and compliance. resists and becomes anxious or angry when issues related to his family are brought up".

The next request for extension for RTC care was dated February 9, 1984, (Exhibit 25). The therapy summary again anticipates a long term stay of "approximately 5 years before permanent personality change occurs and independent living skills are improved to the level necessary for group home and/or community residence." This therapy summary concludes: "Parents remained involved through weekly phone calls, at least semi-annual parent conferences and they receive written quarterly progress reports

from the education and cottage programs. This last three month period has been difficult for and some regression has occurred primarily because of the switch in his supportive aides as well as the two week period he spent home during Christmas vacation. continues to have significant problems immediately prior to and subsequent to his home visits. A specific vacation program was worked out with the parents during this last holiday period and the parents reported that the visit was more successful than most." (Exhibit 25, page 9) OCHAMPUS responded that peer review was necessary before approval could be given because it had been a year since the patient had been placed in residential treatment (Exhibit 26). The submitted treatment plan form (Exhibit 27, page 2) is almost identical to the one submitted a year earlier, with the "family involvement" section the same. Expected length of stay was 4-5 years, with discharge to home.

The file was presented for peer review to the OCHAMPUS Medical Director, who is a Board certified child and adolescence psychiatrist. He concluded that the patient could be treated in outpatient psychotherapy and family therapy and that an acute inpatient level of care or inpatient care in an RTC was not justified (Exhibit 28).

"I am unsure as to why this beneficiary is in a RTC facility. From my review of the information it is apparent that he has had some problems with functioning in the school and home environment, characterized by teasing, whining, crying, withdrawing, some mildly aggressive behavior, stealing, general difficulty in following directions and affecting any kind of insight. It seems that at least one of his problems has been that he is mildly mentally retarded. The ideology which has not been explored here, and is manifested by considerable problems over the years, is why this child has problems functioning in the family environment.

It appears that the child was initially admitted to the RTC because he was primarily acting immature and having difficulty in following directions and cooperating. It is not totally inappropriate that the beneficiary was placed in an intensive program that could give him structure and supervision. However, I see a varied level of professional psychotherapy being provided to him. Psychotherapy is being provided by Ph.D. psychologists once a week, yet we have a very limited amount of information documenting that therapy over a period of several months. Specifically lacking is any justification or explanation about the limited family involvement. We have one comment from Dr. that " continues to have significant problems immediately prior to and subsequent to his home visits." This indicates a severe problem that should be dealt with but which I see very little focus on in individual therapy

or the overall treatment plan. This beneficiary requires an intensive level of family therapy because he has voiced concerns about his family abandoning him. This is the therapeutic issue that is being neglected by this facility. In fact, they are primarily oriented towards educational services for this beneficiary who does in fact need special education."

A letter was sent to the sponsor on April 17, 1984, advising that benefits would be terminated for residential treatment center care as of June 15, 1984, on the basis that the record did not document the medical necessity of continued residential treatment and therefore said care was above the appropriate level of care under the CHAMPUS Regulation (Exhibit 29). The sponsor wrote protesting this decision (Exhibit 30) and this letter was treated by OCHAMPUS as a request for a formal review determination. A request was made for a complete treatment plan tailored to this patient's needs and individual and group therapy reports (Exhibit 33). The material submitted contained a report from the supportive aide working with the patient (Exhibit 34, page 2) showing the patient had shown a marked decline in his ability to comply with requests for a few days before he left for vacation and upon his return from vacation. Although it states he shows no real improvement in his stealing and borrowing incidents, he is doing much better in the area of rudeness to staff and peers and in his teasing of peers. No improvement in his hyperactive behavior was reported, but he had improved in his ability to complete assigned tasks and there had been some decrease in bizarre behavior. The therapy report dated 5/31/84 (Exhibit 34, page 20) finds the patient is demonstrating "gradual and steady progress in all areas listed above". An all encompassing treatment program is still felt to be necessary although significant gains have been made, but the therapist believes these gains are not permanent and without this type of treatment program they will be lost. He states the long term prognosis for permanent improvement under those conditions would be considered poor and, at the present time, if residential care continues for approximately 3 to 5 years he considers the patient's prognosis for a successful return to the community, and at least semi-independent living, to be fair to good. The involvement of the patient's parents is discussed:
" 's parents remain highly involved, caring and supportive of the Devereux Treatment Team. They are kept informed by weekly telephone calls with and his "special" cottage staff, written quarterly progress reports from the Education and Cottage programs, and at least semi-annual parent conferences". The treatment team feels the patient is beginning to benefit from short leaves with his family several times a year and, although the patient does demonstrate some anxiety and problems immediately prior to and subsequent to his home visits, a structured "at home" program has been worked out and the family reported the most recent visit has been the most successful (Exhibit 34, pag 18).

Before the formal review decision was issued, the entire record, including the most recent quarterly report discussed above, was reviewed by the OCHAMPUS Assistant Medical Director, who is a Board certified psychiatrist. In response to a question as to whether the residential care was medically necessary, the Assistant Medical Director concluded the patient was not receiving the type of care he required. Although the RTC report says that the "family is highly involved and caring and supportive of the Devereux Treatment Plan, in that the family is kept informed by weekly phone calls, written quarterly reports and the semi-annual family conferences, but...this does not come under the rubric of appropriate family therapy that would help this child to adjust to the family environment and hopefully be reintegrated into his family environment. This is not considered appropriate care for a child with this mental condition." He concluded the care provided by the RTC was not appropriate because the family should be involved with the child's therapist, "ideally, at least once a week, biweekly or at least once a month; however, this is not happening in this case and therefore, the care at the present time is not medically necessary, and the total plan is not appropriate." (Exhibit No. 35)

The Formal Review Decision issued July 9, 1984, denied CHAMPUS cost-sharing for care provided after June 15, 1985, "as the treatment was not in keeping with the generally acceptable norm for medical practice since the patient was not receiving a totally therapeutic planned group living and learning situation within which adequate parental involvement was integrated." The documentation did not justify the medical necessity for continued residential treatment and therefore treatment was found to be above the appropriate level of care (Exhibit 36). The sponsor filed a timely request for hearing (Exhibit 37).

After receiving the formal review determination, a letter was written by Dr. _____, psychiatrist, and Dr. _____, clinical psychologist, at The Devereux Foundation-California (Exhibit No. 44). It appears the letter was actually written by Dr. _____ and signed in approval by Dr. _____. Dr. _____ writes he is responsible for psychological treatment to the beneficiary and the description of the patient in the Formal Review Decision would indicate to him that the records available to the CHAMPUS reviewers might not accurately describe the patient's emotional and behavioral problems. On paper he could understand how a reviewer might see the problems to be "petty annoyances and minor adjustment and maturity problems primarily related to his mental retardation. In reality, his behaviors represent very significant dysfunction in educational, home, and social settings." The letter describes the patient's destructive and difficult behavior and concludes it is a very difficult set of problems further exacerbated by his mental retardation condition. It is his opinion that the patient requires a highly controlled environment in which treatment conditions can be monitored and strictly manipulated if need be, with this treatment to continue for one to two years. He agrees with the concern for involving the family in treatment and says

it is accomplished by weekly phone calls, written quarterly reports and semi-annual conferences. He reports the amount of parent contact in this case is consistent with the parent contact in other CHAMPUS cases at this facility.

Further peer review of the case was conducted prior to the hearing with the OCHAMPUS Medical Director. This included the above described letter from Drs. _____ and _____ Dr. _____, in his report (Exhibit No. 47), discusses the initial APA peer reviewers estimate of approximately one year and that within this period of time the providers of care should describe and justify progress as occurring which would allow the reviewers to find that the care provided was medically necessary and was at the appropriate level. "In this case we estimated that the patient would need approximately one year in order to progress to the point where he could live in a less structured setting. However, upon reviewing the records, it was determined that progress was being stalled by the facility's, and/or the parent's failure to effectively treat this patient by having the family be involved in the patient's treatment. Family involvement in the residential treatment care of a patient such as this is necessary in order for the care to be considered in keeping with the standards of practice in the United States." He goes on to say it is a clearly established RTC criteria and standard. That there must be "a substantial and significant level of family involvement" and he can find no contraindication in the record to show that the family should not have been actively involved in this patient's treatment: "Ultimately his psychiatric development is dependent on his sense of his place in the family, his relationship with other family members and the resolution of family problems that contributed to his being placed in this facility." The reviewer found that at the time the patient was admitted there should have been some prognosis as to eventual placement; "to return home, or go to a group home or perhaps to a long term facility such as a state hospital. These are questions that required family resolution and should have been dealt with in ongoing family therapy. This was not documented as having occurred in this placement. We can only assume that either the family, and/or the facility was thwarting this necessary process in psychotherapy. This is not only a standard of medical care, but is specifically indicated in this case. This patient's condition was significant enough to require the residential treatment level of care. However the care being provided was not adequate for the evaluation and treatment of his condition, i.e., medically necessary - because it did not include an essential factor, that being involvement of the family. Length of stay and quality of care could reasonably have been adversely affected by the low level of family involvement". The providers of care should have estimated the amount of family involvement that would be necessary in the care of this patient and, if that was not forthcoming, other placement should have been made, the report concludes.

At the hearing both parents testified regarding their involvement with their son and the people treating him. The father

stated he specifically took an assignment at Long Beach, which is away from his home, so he could see his son. He goes at least once a month on the weekends to visit him at Devereux and either they stay in a motel or he brings him back to his apartment in Long Beach. He usually returns to Devereux for Saturday evening because they have a special program on Saturday evening. In response to a question as to his talking to the staff, he said that it was a different staff on the weekends, and while he certainly visited with them when he was there, their biggest contact with the regular staff treating their son was in phone calls during the week. The testimony was that the patient usually flies home approximately every 6 weeks to two months, coming on Friday and going back on Sunday, except for holiday visits when he is home for a longer period of time and also for a month in the summer. His mother testified that she spoke at least once a week with each of his counselors, including his one-on-one counselor, and that the patient calls them on Saturday or Sunday. It was the testimony of both parents that they had never been involved in any formal family therapy since their son had been at the Devereux Foundation, although they had maintained constant contact with him. The parents brought Exhibits 50 and 51 to the Hearing which document phone conversations between the patient's mother and staff. Exhibit 50 documents 17 phone calls from March 22, 1983, to April 5, 1984, in which vacation and travel arrangements were discussed along with the patient's behavior on the hall and at home. Exhibit 51 contains behavioral notes from May 21, 1984, to July 8, 1984. These were kept by his supportive aide who spends 40 hours per week of one-to-one time with the patient, as I understand. They describe the patient's behavior during the time they are together.

Dr. _____, the clinical psychologist who had treated the patient since he was 10 or 11, and prior to his admission to the residential treatment center, described a recent meeting he had with the patient and what he saw as a great improvement in his behavior resulting from the care at Devereux Foundation. He understood the concern for family therapy and felt there had been an informal type of family therapy going on between the family, the staff, and the patient. He described the family as tremendously supportive and concerned regarding their son, and very involved in following what was happening regarding treatment. Dr. _____ testified that Devereux had 77 CHAMPUS patients at the present time and he did find it strange there was no specific treatment modality involving the family. He saw the eventual prognosis for this young man as a semi-independent type of living situation and felt it was possible, with therapy and training, that the patient might be able to hold a job. Dr. _____ had never met a family whose involvement and advocacy for their son was stronger and he realized how very difficult it was for them to let go of their son to allow him to go to this treatment facility, especially for the mother. They have done very well regarding this release. He reported he had seen the patient on his visits home and he was making what Dr. _____ described as "massive gains with great improvement in adjustment shown on his behalf". When he

heard of the OCHAMPUS denial, he felt there must be a mistake someplace, especially since it appeared CHAMPUS made no suggestions nor had it given the program any opportunity to change, but had just summarily terminated benefits. He described his previous extensive involvement in the military and expressed his concern over how CHAMPUS had handled what it perceived to be a deficiency in the treatment plan and program. He testified that family therapy would be helpful, ideally once a month, and that he was a great believer in family therapy. He felt, in his opinion, the ideal treatment plan would have at least monthly therapy visits which would involve all family members, including the patient's brothers. Discussions would include the goals for the treatment plan and eventual placement for the patient. He was equally adamant in his testimony that the patient had made great progress and had suffered in no way from the family not being involved to this point. It was his recommendation that the patient be allowed to remain at Devereux and that suggestions be made to set up a treatment plan. In response to my question as to whether the patient was receiving psychiatric/psychological therapy, he answered that was probably not the case, although he felt what the patient was receiving certainly constituted psychiatric care. He described his understanding of the treatment as a very strong educational program with a small amount of psychological/psychiatric therapy; that the real value of the program is the milieu therapy the patient receives and this is the key to his improvement. This 24 hour day, 7 day a week, involvement with all aspects of his life, (social/living skills/educational), is what is allowing the patient to make the progress he is making. Dr. described treatment as more social milieu therapy with educational emphasis.

Additional witnesses at the hearing were Ms. , the Director of Special Education for Liberty High School, and Ms. , Program Specialist, Contra Cost Special Education Local Planning District, both of whom were involved with the beneficiary when he was at home and receiving services from the school district and other local agencies. Ms. stated theirs was a relatively small school district so they turned to the county for placement for multiply handicapped children and all available placements had been tried for this beneficiary but had been found to be inappropriate. She was familiar with other programs and testified she was certain there was no other appropriate placement in California for this young man, although she had recently come to this decision and was familiar with the beneficiary only on paper prior to visiting him in September, 1984. She said his progress was outstanding from the reports and background that she had read compared with her actual meeting him in person in September. She also emphasized she had never worked with a family as supportive as this patient's family. Coping with children with these types of multiple handicaps destroys most families and it was her testimony that this family had coped beautifully with these problems. In response to a question, she stated that family therapy would always be helpful. Her concern would be the young brothers of the patient benefiting from family counseling. It was her pro-

jection that the patient with intensive treatment would be able to live at least semi-independently as an adult.

Ms. knew the patient because the agency with which she is associated provides service for a large area of 16 school districts. She was personally familiar with the patient in that she had visited his classroom when he was in a local school class for handicapped students. She testified she had gone to Devereux in June, 1984, to visit for an afternoon and she was amazed with the patient's progress and found it hard to believe it was the same person she had observed in the local program. Both she and Ms. felt it was the continuity of the program that was important in that there was follow-through and an opportunity to do behavior modification because of the school/living/treatment aspects all being in the same location and supervised. It was her testimony that the IEP team was responsible for school district placement for this patient and the school district would be responsible for the educational component of care.

The appealing party brought several letters from people involved with the beneficiary at Devereux Foundation. One of these (Exhibit No. 48) was written to OCHAMPUS from , the Admissions Representative. This letter states that Devereux in California has long been an OCHAMPUS provider and was one of the facilities that was used as a model for OCHAMPUS coverage of residential placement and, by recent approval, their treatment is consistent with the JCAH Consolidated Standards Manual. He reports that the family lives 350-400 miles from the facility and it would not be practical for them to participate in family therapy as outlined in the Formal Review Decision. To compensate for this lack of family therapy, they have utilized weekly phone calls shared by all of the staff, regularly scheduled conferences and periodic reports. This is the type of contact that they use with all of their residents, including many other OCHAMPUS authorized clients. He continues "Since they have been deemed inappropriate in the case, we must assume that any residential treatment outside of the immediate locality is considered by OCHAMPUS to be inappropriate for him. This is a major point of contention for those of us who have worked with ". He goes on to state there are steps which could be taken to increase the family's involvement and that the Devereux Foundation would be receptive to suggested modifications in Larry's treatment plan. He feels it would be more reasonable to adjust that single aspect of the patient's treatment than to deny him the entire level of care, but no opportunity to do that was given.

Another letter was sent to the appealing party but addressed TO WHOM IT MAY CONCERN from , Clinical Psychologist (Exhibit No. 49). This letter is essentially the same as the letter written to OCHAMPUS Appeals and Hearings which is Exhibit No. 44. Exhibit No. 52 is a report written to the appealing party from the Residential Supervisor and the Supportive Aide on the unit. The letter in Exhibit No. 52 is a duplication of

Exhibit No. 34, page 2, and the report is a duplication of Exhibit No. 34, page 20.

At the hearing it became clear that the amount in dispute in this hearing was not known. The witnesses from the school district were unclear as to what they had paid and the sponsor was not aware of what amount was unpaid and owed by him, if any. I obtained a release from the sponsor and wrote to the admissions representative at the Devereux Foundation-California (Exhibit 54). A response was received from the accounts department showing that a balance of \$18,234.50 was due and owing through September, 1984. The charge had been somewhere between \$2,400.00 and approximately \$2,800.00 per month. Payments had been made by CHAMPUS through February, 1984, and either Contra Costa Special Education District or Liberty Union School District had paid the charges which remained unpaid after the CHAMPUS payment.

I gave OCHAMPUS an opportunity to comment on this additional information and a letter was received from Ms. on December 4, 1984 (Exhibit 59). In response to my question as to why CHAMPUS payments had not been made through June 15, 1984, OCHAMPUS replied that in checking with their fiscal intermediary they were told that no claims had been submitted after February, 1984. This letter also points out that the school district paid the sponsor's cost share amount. In its response OCHAMPUS took the position that, under Chapter IV.2.G of the CHAMPUS Regulation, services and supplies related to either general or special education are not a covered CHAMPUS benefit and the only exception is where appropriate education is not available from, nor payable by, the applicable public entity. Testimony at the hearing had indicated educational services required by the beneficiary were not available from their school district but both the Contra Costa Special Education District and Liberty Union High School District had provided funds for the beneficiary while he was at Devereux. OCHAMPUS took the position therefore that the exception to the regulatory provision did not apply and the educational expenses and costs, inasmuch as they were included in the blanket charge of the provider, are not a CHAMPUS benefit and should not be cost shared by CHAMPUS from the period of time when the beneficiary entered the RTC on February 21, 1983, through February 28, 1984, which was the period of time for which CHAMPUS benefits had already been cost shared.

The sponsor replied, reiterating that there was no appropriate educational facility in the home county and emphasizing they had undertaken all of the required documentation necessary to get CHAMPUS approval. It was pointed out they had been advised by OCHAMPUS that they would have to pay the cost share amount of approximately \$6.00 per day and the school district, after lengthy meetings and research, took on the responsibility of paying that costs share amount to relieve the sponsor of some of the financial pressure (Exhibit 61).

The sponsor asked the Devereux Foundation to respond to this additional information and the OCHAMPUS position regarding educational costs, and it did so by letter dated January 7, 1985 (Exhibit 64). In this letter the Devereux Foundation stated billing had been discontinued at the end of February, 1984, because authorization for CHAMPUS to continue benefits had only been recently received. They confirmed that if CHAMPUS discontinued its benefits the sponsor would be responsible for payment and that the school district had paid the sponsor's portion. They reported the educational cost for the 1983-84 school year was \$775.00 per month.

OCHAMPUS responded to the information contained in this letter and reiterated its position that the educational costs now identified as \$775.00 per month were excluded from CHAMPUS coverage during the entire period of authorized care (February 21, 1983, through June 15, 1984) and if it is my decision that OCHAMPUS coverage should be continued, the educational component would be excluded from coverage (Exhibit 67).

ISSUES AND FINDINGS OF FACT

The primary issues in dispute are whether the care provided to this beneficiary was medically necessary and appropriate care after June 15, 1984 and whether the educational component of the RTC charge is a CHAMPUS benefit. Secondary issues that will be addressed include payment of other claims/estoppel and burden of evidence.

Chapter 55, Title X, United States Code, authorizes a health benefits program entitled Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Department of Defense Appropriation Act of 1979, Public Law 95457, appropriated funds for CHAMPUS benefits and contains certain limitations which have appeared in each Department of Defense Appropriation Act since that time. One of the limitations is that CHAMPUS is prohibited from using appropriated funds for "...any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury or body malfunction as assessed or diagnosed by a physician, dentist, or clinical psychologist..."

Department of Defense Regulation DoD 6010.8-R was issued under the authority of statute to establish policy and procedures for the administration of CHAMPUS. The Regulation describes CHAMPUS benefits in Chapter IV, A.1 as follows:

"Scope of Benefits - Subject to any and all applicable definitions, conditions, limitations and/or exclusions specified or enumerated in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care. Benefits include specified

medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional providers, as well as professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment".

Chapter II of the Regulation, Subsection B, 104, defines medically necessary as "the level of services and supplies, (i.e., frequency, extent and kinds), adequate for the diagnosis and treatment of illness or injury. Medically necessary includes concept of appropriate medical care". Chapter II, B. 14, defines appropriate medical care in part as "That medical care where the medical services performed in the treatment of a disease or injury are in keeping with the generally acceptable norm for medical practice in the United States," where the provider is qualified and licensed and "the medical environment where the medical services are performed is at the level adequate to provide the required medical care". Chapter IV, paragraph G provides in pertinent part: "In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other Chapters of this Regulation, the following are specifically excluded from the CHAMPUS Basic Program:

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

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

43. Educational/Training. Educational services and supplies, training, nonmedical, self care/self help training in any related diagnostic testing or supplies. (This exclusion includes such items as special tutoring, remedial reading, natural childbirth classes, etc).

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

Chapter IV, B.1, provides that, "Benefits may be extended for those covered services and supplies provided by a hospital or other authorized institutional provider when such services and

supplies are ordered, directed and/or prescribed by a physician and provided in accordance with good medical practice and established standards of quality".

The requirements of care rendered at an appropriate level is repeated in paragraph B.1(g): "Inpatient: Appropriate Level Required. 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..." (h): "General or Special Education Not Covered. Services and supplies related to the provision of either regular or special education are not generally covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the reasonable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception to this circumstance is when appropriate education is not available from or not payable by the cognizant public entity. Each such situation must be referred to the Director, OCHAMPUS (or a designee) for review and a determination of the applicability of CHAMPUS benefits.

Chapter II describes CHAMPUS residential treatment centers for emotionally disturbed children in Section B.155. "Residential treatment centers (RTC) mean institutions (or distinct units of an institution) existing specifically for round-the-clock long term psychiatric treatment of emotionally disturbed children who have sufficient intellectual potential for responding to active psychiatric treatment, for whom outpatient treatment is not appropriate and for whom inpatient treatment is determined to be the treatment of choice. RTCs do not provide domiciliary and/or custodial care, but rather, must be able to provide a total therapeutically planned group living and learning situation within which individual psychotherapeutic approaches are integrated". To be approved by CHAMPUS, RTC's must be accredited by the JCAH under the Commission Standards for psychiatric facilities serving children and adolescents and enter into a Participation Agreement with OCHAMPUS which requires that the RTC will comply with the CHAMPUS standards (Chapter II B.155. A and B). Preauthorization is required for treatment in a RTC (Chapter IV.B.1.b.) and a detailed treatment plan must be submitted for approval (Chapter IV B.4.C.)

ISSUE: Should CHAMPUS benefits be authorized for RTC care provided to this beneficiary after June 15, 1984?

The OCHAMPUS position on this issue, as stated in the Formal Review Decision, is that inadequate parental involvement was integrated into the therapeutic group living and educational situation for the patient and this was not in keeping with the generally acceptable norm for medical practice in the United States. In addition, the medical necessity for continued resi-

dential treatment was not documented and therefore was above the appropriate level of care required to treat this beneficiary.

I believe it is important to emphasize at the beginning of my discussion that a residential treatment center is a highly specialized institution to provide round-the-clock, rather long term, active psychiatric treatment to emotionally disturbed children and adolescents where outpatient treatment is not appropriate. It is first and foremost a psychiatric institution and requires that residents have sufficient intellectual potential to respond "to active psychiatric treatment". A CHAMPUS approved residential treatment center is not a training institution for people with developmental disabilities and delays and domiciliary and custodial care is specifically excluded. It is against this standard that I must judge the factual situation in this case to see if additional benefits may be authorized.

When the request for preauthorization for RTC care was initially submitted, the beneficiary was described as having a profound emotional disturbance. He had been placed in the school district's program for the severely emotionally disturbed, but it was determined that placement was inappropriate and RTC care was necessary. The American Psychiatric Association peer reviewer, after examining the record, was concerned that he was not provided a treatment plan and one felt some concern as to whether the beneficiary had sufficient intellectual potential to respond to active psychiatric treatment. One reviewer felt that RTC placement was appropriate on a trial basis and should be reviewed in six months. The reviewer who questioned whether the patient would be able to take advantage of active psychiatric treatment felt that an examination should be made at the end of a year. From the time of the initial authorization, concern was expressed as to the appropriateness of RTC placement for this patient, the specifics of the proposed treatment, and a need for review and monitoring as to placement. The treatment plans which are submitted in Exhibit 27 show that one hour of individual psychotherapy a week with _____ Phd., (Psychology) was the treatment along with group therapy, as needed, by the cottage staff. I agree with the medical director's observation that there is almost no documentation in this record of psychotherapy over a period of a year and a half.

All of the witnesses who testified at the hearing gave descriptions of the improvements made by this beneficiary in the areas of social behavior and learning ability after his placement in the RTC. They reported it was hard to believe it was the same person who had gone there some time before and whom they had not seen in the interim. While it is always personally satisfying to hear of the gains made by a person in a treatment program, whether or not a particular beneficiary improves or does not with any given treatment cannot be the basis for my decision and in making this decision I am not finding this treatment program has not helped and improved the beneficiary's condition. OCHAMPUS is a benefits program authorized by Congress and the enabling legislation contains certain restrictions on coverages

as does the implementing Regulation, which has the force and effect of federal law. I have quoted above major portions of this Regulation which concern this hearing and a reading of the entire Regulation clearly shows the intent was that the family would be involved in the treatment process in a RTC. In Chapter IV, where the preauthorization requirements are discussed, the Regulation provides that, for even otherwise covered admissions, the proximity to the parent's residence will be a consideration in whether or not authorization will be granted (Chapter IV.B.4). In Appendix A, which sets forth CHAMPUS standards for psychiatric residential treatment centers there is a requirement that objectives and policies of the center shall be stated and the plan of operation shall include, among other things, "methods to involve family members" (Appendix A 1.B.2). Other requirements are that a psychiatrist be in charge of the program and there should be a complete psychiatric assessment. As part of this there shall be an environmental/family/social assessment with "evaluation of past events and current problems that have affected the patient and the family, goals of family regarding patient's treatment, to include their expected involvement and expectations as to the time frame treatment will be required". (Appendix A F.1.c.8). There is a requirement that the patient's clinical record shall include records of therapy sessions (G.1.k.).

I have carefully examined the record and considered the testimony at the hearing. It is a very difficult decision to deny CHAMPUS coverage for care for this young man who does not seem to fit into any other treatment/educational environment. I believe that the parents, to a certain extent, see this as a possible long term care situation with even some discussion at the hearing about the beneficiary remaining there and being in a workshop/adult living program. The record indicates the patient has benefitted from the total milieu treatment and I can certainly understand their wanting him to remain in this environment. Their satisfaction with the program was eloquently expressed at the hearing by the parents. CHAMPUS benefits for residential treatment center care are by definition and in practice limited to those for active round-the-clock intensive psychiatric treatment. It is the opinion of both the OCHAMPUS Medical Director and the Assistant Medical Director, both of whom are psychiatrists that active psychiatric treatment of adolescents must involve the family and anything less than that is not in accordance with good medical practice and established standards of quality. Both point out the record indicates the patient has some problems in the area of his family relationships and that with active therapy addressed to this issue the patient's progress and prognosis might be improved, and the time for RTC care shortened.

The record supports this conclusion by the peer reviewers. The psychiatric evaluation prior to placement estimated RTC placement at two years (Exhibit 7). The initial treatment plan estimated six years with the patient returning to his home. In a letter written after the formal review decision by Dr. ~ ~ ~

there is an estimate of one to two years continued treatment. At the hearing the parents were discussing the possibility of a rather permanent placement. The Regulation requires that this issue be addressed as part of the treatment process and it seems evident it would be a primary subject for family therapy. If this has been a subject of consultation and discussion between the parents, the patient and the treatment staff, there is nothing regarding it in the record.

Some concerns regarding the patient and his family are evident in the record. The psychologist who evaluated the patient for placement suggested the parents accompany him during the first week of RTC placement so that he would not decompensate for a period of time (Exhibit 6). Nothing in the record shows whether this was done or not. Dr. [redacted] in his outpatient treatment spent part of each treatment session with the mother to "process, clarify and reformulate parenting issue and styles" (Exhibit 10). The APA peer reviewer was concerned about the lack of information regarding family/peer relationships (Exhibit 20). In the therapy report submitted by Dr. [redacted] for purposes of continued authorization it states: "[redacted] is non-compliant immediately prior and subsequent to home visits and resists and becomes anxious or angry when issues related to his family are brought up" (Exhibit 24). The "significant problems" around family vacations are mentioned again in the therapy report of February, 1984 (Exhibit 25). Dr. [redacted] describes the patient as having very significant dysfunctions in educational, home and social settings (Exhibit 44). The treatment records show the educational and social dysfunction was being actively addressed in the treatment program, but little attention is directed to the home/family dysfunction.

Throughout the records the standard referral to family involvement by the RTC is: parent conference semi-annually, written quarterly reports, weekly phone calls and vacations at home. There are quarterly reports (concerned primarily with school progress) and the parents said they called their son once a week and had school vacation visits home, along with some interim weekends. There is no documentation of any semi-annual conferences. The father testified he had taken an assignment to be close to his son and that they were together at least one weekend a month. He seldom sees the people providing treatment because they have a different staff on the weekend and he was seldom there during the week. It is clear from the testimony that this is a very caring, supportive, involved, concerned family. They testified that although it would be difficult they would go for family therapy, but no one at the RTC had ever suggested it. Some parts of [redacted] s final report might be read to indicate the record shows a family that was unwilling to participate. Testimony at the hearing clearly showed this was not the case; the family has no problems or resistance to being involved, but a request has never been made.

Dr. [redacted], who has a long relationship with the beneficiary, testified that he is a great believer in family therapy for

children and adults and was rather surprised this was not undertaken by the treatment team at the residential treatment center. He felt that ideally the treatment plan would have, at the minimum, monthly therapy visits involving all family members, including the siblings, with discussions regarding the treatment goals and eventual placement. Ms. also agreed that family therapy would be helpful with all patients. In this case she felt it would especially be of benefit to the young brothers of the beneficiary. Both of these professionals insisted that even though this was not done, the patient had still made great gains.

It was also suggested that through phone calls "informal" family therapy did take place. Concern over the daily progress of the patient, making arrangements for trips home, etc. are not family therapy as that term is generally used in an intensive psychiatric treatment program and was envisioned in the discussion at the hearing with Dr. and Ms. , nor is it what Dr. and Dr. meant in their medical peer review reports when they were discussing the need for family therapy. Also, the record shows no contact with the patient's siblings which is an important area if the patient is to return home. It is possible that some of this apparent omission is due to lack of notes in the medical records. RTC's are by definition to provide active psychiatric treatment and records must be maintained. A prior CHAMPUS decision involving inpatient psychotherapy held: "It is usual and customary for therapists to record notes of their sessions with patients. In the absence of such notes or other appropriate documentation, it is difficult to determine that services were actually performed or that the services were appropriate and medically necessary in the treatment of the patient" (OASD (HA) 83-10). The medical reviewer was concerned over the limited amount of information available for what was stated to be weekly psychotherapy and group therapy. The problems relating to family were identified in the therapy reports mailed to the parents, but documentation regarding any attempt to treat this issue is lacking. I agree with the conclusion of the reviewer that the facility is neglecting this important therapeutic issue.

It is my conclusion based on the record that the standard of care in treating children and adolescents is that the family be involved in the therapy, not just as a concerned, supportive person, but actually as a part of the therapeutic process. This patient demonstrated some serious problems in dealing with his family. The goal of any residential treatment center program must be to allow the young patient, through active psychiatric care, to be returned to society with the eventual goal in this, as in most cases, of being part of their family.

In his testimony at the hearing Dr. described his involvement with the military and said he was surprised at the way this case was handled. When he first heard of the CHAMPUS denial he felt there must be a mistake because it appeared CHAMPUS made no suggestions, nor had they given the program any

opportunity to change, but had just summarily terminated benefits because of what they perceived to be a deficiency in the treatment plan. His testimony indicated he also felt there was some deficiency in the treatment plan and I understand his concern that the beneficiary and his parents seem to be the ones who are losing most by the denial when the facility is in a better position to do something about any deficiencies in their treatment plan. I frankly was a little surprised at the sequence of events in this case myself, but for a different reason than Dr. . I cannot agree with his characterization of what happened in this appeal. Residential treatment center care is a special benefit program for which there is a need for preauthorization and continued review of that authorization. That is what occurred in this case. The sponsor received word on April 17, 1984, that benefits would be denied after June 15, 1984. While this letter generally bases the denial on care above the appropriate level, this two month period left a fair amount of time for inquiry. I do not know what transpired during that period except what is in the hearing file, which is a request from OCHAMPUS for a treatment plan tailored to the patient's needs and submission of the progress report and a treatment plan almost identical to the original treatment plan. Certainly by July 9, 1984, when the formal review decision was issued it was very clear the basis for the denial of preauthorization was due to lack of a treatment plan providing for parental involvement in family therapy. While this decision was issued after the date benefits were terminated on June 15, 1984, I can only conclude that consideration would have been given by OCHAMPUS to a submitted treatment plan which corrected this deficiency. There is no indication that such a change was made by the provider in their treatment approach nor was a new treatment plan submitted, at least by the time of the hearing which was October, 1984. Because RTC's are a costly, intensive treatment provider the Regulation requires preauthorization for treatment. It has been determined that this facility, in treating this patient, has failed to document treatment of an important therapeutic issue and preauthorization for continued treatment cannot be approved.

ISSUE: Is the educational component a CHAMPUS benefit during the period of authorized RTC care? The issue which was raised at the hearing, and developed subsequent to the hearing, is that part of the services provided to this beneficiary are educational in nature and, pursuant to the CHAMPUS Regulation, the daily charge related to education must be determined and deleted from the institution's charges before CHAMPUS benefits can be extended. The educational monthly charge has been determined by Devereux and identified as \$775.00 per month. Pursuant to the Regulation this amount cannot be allowed as a CHAMPUS benefit and the only exception is where appropriate education is not available from, or not payable by, the applicable public entity; in this case the school district.

Testimony at the hearing established that an appropriate education for this beneficiary is not available in the local school

district. This testimony also indicated that some payment had been made, as is confirmed by the accounting received in Exhibit 57. Therefore, the cost of the educational component is payable by the school district and should not have been cost-shared by CHAMPUS during the period when care was authorized from February 21, 1983, through June 15, 1984. A phone call from the beneficiary's mother advised me that the cost of the educational component would be paid by the school district.

PAYMENT FOR OTHER BENEFICIARIES/ESTOPPEL

Mr. . . . , the admission representative at the Devereux Foundation, wrote a letter for purposes of this appeal (Exhibit 48), in which he raised the issue that CHAMPUS paid for other beneficiaries who were residing at the school in California. This issue was also raised by Dr. . . . in his testimony. If by this argument these providers attempt to raise the issue of estoppel, it is not applicable to this hearing. I cannot base my decision on what may have been done with other patients. Their treatment plan is not before me in this hearing nor are their individual and family therapies. If other similar claims have been paid erroneously or authorized based upon a different or similar circumstance, this cannot be the basis for my decision as the federal government is not estopped by erroneous actions of its agents and employees. A previous Final Decision of the Assistant Secretary of Defense (Health Affairs) has stated: "This argument is essentially an estoppel argument. This office has held in numerous final decisions that the doctrine of estoppel does not apply to erroneous acts of the Government's agent (fiscal intermediary) in cost-sharing non-covered charges" (OASD-HA 84-18).

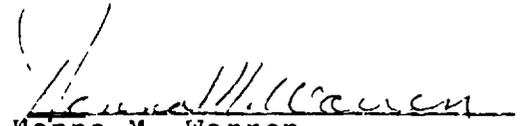
BURDEN OF PROOF

A decision on a CHAMPUS claim on appeal must be based on evidence in the hearing file of record. Under the CHAMPUS Regulation the burden is on the appealing party to present whatever evidence he or she can to overcome the initial adverse decision. I have concluded the appealing party has not met this burden as regards care after June 15, 1984. Inpatient psychiatric care for this adolescent which does not involve family therapy is not appropriate medical care in keeping with the general accepted norm for medical practice in the United States and is thus by Regulatory definition not medically necessary. I have also concluded the appealing party has failed to meet his burden as regards the educational component of the services rendered at the residential treatment center. While these educational services are not available in the local school district, funds are available to pay for its cost. The Regulation is specific as regards the exclusion for general and special education and CHAMPUS benefits cannot be extended for these services.

SUMMARY

It is the recommended decision of the hearing officer that benefits at the Devereux Foundation-California Residential Treatment Center be approved for this beneficiary as authorized from February 21, 1983, through June 15, 1984, but authorization for benefits after that date be denied as an important therapeutic issue has not been addressed as is required for appropriate, medically necessary care under the CHAMPUS Law and Regulation. It is further my recommended decision that during the period when RTC benefits are authorized, the identified educational cost of \$775.00 per month be deleted before CHAMPUS benefits are paid, as these educational costs are specifically excluded by CHAMPUS Regulation.

Dated this 18th day of February, 1985.


Hanna M. Warren
Hearing Officer