ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

31 MAR 1980

HEALTH AFFAIRS

FINAL DECISION: [redacted] Appeal
[redacted] Ph.D., Appealing Party)
OASD(HA) Case File 16-79

The Hearing File of Record and the Hearing Officer's RECOMMENDED DECISION (along with the Memorandum of Concurrence from the DIRECTOR, OCHAMPUS) on OASD(HA) Appeal No. 16-79 have been reviewed. The appealing party in this case is a clinical psychologist--i.e., a participating provider of care. The beneficiary/patient was not involved in the appeals process, although the record shows she was aware that an appeal action had been initiated. The amount in dispute in this case is $1,690.00. It was the Hearing Officer's recommendation that the Contractor's initial determination to deny CHAMPUS benefits for concurrent individual psychotherapy services rendered from 20 September 1977 to 28 February 1978, a period during which attending psychiatrists were rendering similar services, be upheld. It was his finding that the existance of a crisis situation, which would permit the extension of additional psychotherapy benefits for the purpose of intervention, had not been established or substantiated. The Principal Deputy Assistant Secretary of Defense (Health Affairs), acting as the authorized designee for the Assistant Secretary, concurs with this Recommendation and accepts it as the FINAL DECISION.

PRIMARY ISSUE(S)

The primary issue(s) in dispute in the case are first, whether the patient's mental condition was so complex and severe as to warrant concurrent individual psychotherapy by two primary practioners and second, whether the patient was in a crisis situation when the appealing party rendered his psychotherapeutic services.

In connection with concurrent care, the applicable regulation states, "If during the same admission a beneficiary receives inpatient medical care...from more than one physician, additional benefits may be provided for such concurrent care <u>if required because of the severity and complexity of the beneficiary's condition</u>." (<u>Reference</u>: DoD 6010.8-R, CHAPTER IV, Section C,

Paragraph 3.b.) The Regulation further defines inpatient medical care to include "inpatient psychotherapy." The applicable regulation also limits psychotherapeutic services to a maximum of one hour of therapy per twenty-four (24) hour period, inpatient or outpatient, except for the purpose of crisis intervention when up to two (2) hours of therapy per day may be considered. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C, Subparagraph 3.i.(1)) Further, the regulation defines an attending physician to be, "...the physician who has the primary responsibility for the medical diagnosis and treatment of the patient... under very extraordinary circumstances, because of the presence of complex, serious and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently needing treatment during a single period of time." [emphasis added] (Reference: DoD 6010.8-R, CHAPTER II, Section B.16.)

The appealing party raised several points in supporting his position that CHAMPUS benefits should be extended for the psychotherapeutic services he rendered. However, it is the finding of the Principal Deputy Assistant Secretary of Defense (Health Affairs) that the Hearing Officer's RECOMMENDED DECISION was a proper one based on the evidence presented and that his rationale and findings were substantially correct on the issue of the presence of a crisis. However, the decision was deficient in that it did not specifically speak to the issue of concurrent care. To be sure the appealing party fully understands the underlying bases upon which the initial denial is being reaffirmed and upheld, each of the points presented is addressed in this FINAL DECISION.

- Severity of Patient's Mental Illness. First it was claimed by the appealing party that the patient's mental illness was so serious and severe that it justified two primary practitioners rendering concurrent individual psychotherapy to the patient. The clinical information submitted in this case was minimal. The patient did appear to have significant symptomatology prior to her initial hospital confinement. She had agreed to outpatient psychotheropy with the appealing party which apparently intensified some of her symptoms, particularly suicidal and homicidal ideation, and it was determined hospital confinement was required. There was no evidence presented of aggressive or self destructive acts prior to confinement, however. Symptoms presented on admission to the hospital were related as anxiety, depression, aggitation, anorexia and insomnia. While the Hearing File of Record suggests the existence of a significant mental disorder for

which hospital confinement was no doubt appropriate, because complete clinical records were not provided, it was not possible to support a finding that the patient's condition was of such severity and complexity that she required, in addition to the hospital confinements and the attending psychiatrists, concurrent in-hospital individual psychotherapy by more than one primary practioner. The regulation speaks to the issue of concurrent in-hospital medical care provided by more than one physician. While in this case the appealing party is a clinical psychologist rather than a physician, the intent of the regulation is clear and it would not be reasonable to apply less restrictive standards to the services of a clinical psychologist than to a physician. In the absence of clinical evidence indicating that the patient's condition was so severe and complex as to require concurrent individual psychotherapy, a negative finding must be assumed. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C, Paragraph 3.f.)

o Concurrent Inpatient Medical Care (i.e., Concurrent Individual Psychotherapy). Throughout the Hearing File of Record as well as in oral testimony the appealing party continued to maintain that the concurrent inpatient care by two practitioners was justified. The appealing party further claimed he was the primary practioner rendering individual psychotherapy--that the two psychiatrists in the case were, in fact, rendering medical services not psychotherapeutic services. However, this is contradicted in that the Hearing File of Record contains claim forms which have been certified to by the attending psychiatrists, billing for psychotherapy rendered during the same time period as the appealing party. While it is true that one of the psychiatrists also provided chemotherapy, no evidence was presented which would indicate the psychiatrists in the case did not render the psychotherapy for which they billed. Because the first psychiatrist rendered only thirty minute therapy sessions (as opposed to the one hour permitted by the Program during a twenty-four hour period), an effort was made to justify extending benefits for the other thirty minutes of unused therapy time to the appealing party. However, because the lack of clinical records precluded a finding that the patient's condition was sufficiently severe to permit concurrent essentially independent therapy from two primary practitioners, such an approach could not be considered. Benefits cannot be extended for services in excess of Program limits, regardless of the alledged exception circum-

stances, if it cannot be conclusively determined that the exceptional circumstances actually existed. (References: CHAMPUS Regulation DoD 6010.8-R, Chapter IV, Subsection A.5 and Subsection 3.f)

o Crisis Due to Potential Suicide. It was maintained by the appealing party that the potential for suicide in the patient constituted a crisis situation. The minimum documentation available does indicate there was suicidal ideation in this case; actually such potential is inherent in most depressed patients. However, in this case the patient apparently openly revealed some suicidal indication and the potential crisis was anticipated; "intervention" must be assumed to have occurred at the time she accepted confinement in a hospital where a structured, protective, controlled environment could be provided. The degree of seriousness which was attached to the patient's suicidal potential cannot be assured, however, since during the patient's initial hospital admission there was no evidence presented to indicate any suicide precautions were instituted. Even after an overdosing incident at the first hospital, only minimal suicidal precautions were put into effect at the second (transfer) hospital. This may have been due to the fact that there was some question as to the motivation behind the overdose. There was no documentation made available that would support a finding that the concurrent individual psychotherapy rendered by the appealing party either constituted crisis intervention or that crisis intervention other than hospital admission was required. This is not to indicate that the presence of suicide potential does not indicate a significant symptom. However, whether or not there was present in this case an intermittant threat of suicide (which cannot be ascertained due to the limited clinical records), it would not necessarily constitute a crisis situation since the protective intervening measures of hospital confinement were readily available. Therefore, even if it could have been ascertained that the patient's condition was sufficiently complex and severe to require two primary practioners, it simply was not established that the concurrent inpatient individual psychotherapy rendered by the appealing party was necessary to intervene in a crisis due to suicidal potential. Additional benefit consideration for crisis intervention due to suicidal potential was not established. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Section C., Subparagraph 3.i.(1))

- Crisis of an Ongoing Therapeutic Nature. The appealing party also claimed that in addition to the potential suicide problem in this case, there existed a second ongoing crisis situation which he identified as a "crisis of a therapeutic nature." First this description of a crisis situation is internally contradictory. It is generally accepted that a crisis is an acute, short-term situation--a turning point for good or bad in a patient's condition--and in the psychotherapeutic environment usually associated with overt destructive acts either to self or to others. In this case what the appealing party meant is not fully clear but appears to relate to a situation which is the result of therapy, not the therapy being the result of specific crises. The appealing party stated that therapy was directed at assisting the patient in dissociative states in which she relived and revealed past traumatic experiences--i.e., a form of dissociative cathersis. From the limited information in the Hearing File of Record and the oral testimony it would appear that the analytically oriented therapy was used to ascertain underlying causes of the symptomatology. According to statements submitted by the appealing party, that because the reliving of past experiences intensified the suicidal ideation, longer and more frequent therapy sessions were required. From this it could be concluded that this type of therapy had at least some potential to create crisis rather than eliminate it. (It was the opinion of one reviewing physician that the therapy rendered by the appealing party probably contributed to the exacerbation of the patient's illness rather than relieving her symptomatology.) In any event, the existance of a crisis of an ongoing therapeutic nature was not confirmed or substantiated by any documentation other than personal statements submitted by the appealing party nor is the concept of an ongoing therapeutic crisis acceptable. Since the crisis has neither been defined adequately or substantiated conclusively, additional consideration for crisis intervention is not possible. (Reference: DoD 6010.8-R, CHAPTER IV, Section C, subparagraph 3, (i) (1)).

- Crisis Due to Drug Overdose. It was implied that the fact the patient overdosed at the hospital (to which she was initially admitted) also created crisis situation. As stated previously, there is a strong question (acknowledged by the appealing party) as to whether the overdose was actually a suicide attempt or merely an accident related to

indulging in overuse of non-lethal drugs. [1/] The overdoes did result in a short term crisis--but a medical one, not one of a psychotherapeutic nature. The patient was placed in intensive care for a short period under the care of a urologist. According to the physician's report, the patient recovered fully. The next intervention was to transfer the patient to another hospital to remove her from the influence of drug-oriented fellow patients. This could be considered a crisis prevention measure. However, neither the overdose incident itself nor the need to transfer the patient required crisis intervention psychotherapy from the appealing party. Again, additional benefit consideration for crisis intervention due to the drug overdose cannot be supported. (Reference: CHAMPUS Regulation DoD 6010.8-R CHAPTER IV, Section C. Subparagraph 3 i(1))

Our review indicates there was not sufficient clinical information made available in this case to support the appealing party's claims that the severity and complexity of the patient's mental condition and/or crises related to her mental illness justified either his providing concurrent individual psychotherapy or an exception for crisis intervention.

SECONDARY ISSUES

Several secondary issues emerged in this case.

1. Program Right to Information: Lack of Adequate Case Documentation. The Hearing File of Record did not contain adequate information which permitted findings of the

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1/ In his RECOMMENDED DECISION, the Hearing Officer states, "With some uncertainty [the appealing party] testified that far from attempting to kill herself [the patient] may very well have been induced to overdose with Sinequan by drug-oriented fellow immates. His statement takes on credibility when [the appealing party] declared [the patient] was transferred immediately from [first hospital] to another hospital for the sole purpose of separating her from this environment. It need hardly be pointed out that being persuaded by others to take drugs not necessarily lethal, is not supportive of a serious attempt at self-destruction." [emphasis added]

presence of the exceptional conditions being claimed. In order for the case to receive proper review, it required that the complete hospital records on all related admissions be provided as well as the therapists' notes. These clinical records were requested but not made available. A request for additional clinical information was specifically refused by the appealing party. In fact, one of the findings of the Hearing Officer was that the appealing party "improperly withheld pertinent evidence." The patient, who received the disputed phychotherapeutic services, was aware that an appeal was being pursued and that additional information was being requested. Although she had a vested interest in the outcome of this appeal, no effort was apparently made by the patient to see that necessary medical information was released in order to assure proper review of the case. In fact, although there is nothing in writing from the patient in the Hearing File of Record, the appealing party claimed that his patient had directed him not to release any clinical information. The applicable regulation provides that CHAMPUS has a right to any and all information the Program deems necessary to adjudicate benefits. While the decision to release such information rests with the beneficiary/patient, where there is a question as to whether or not a service/supply being claimed qualifies for benefits, absence of such requested information can and will result in a denial. The Program cannot authorize the payment of its funds unless it can be clearly established that such use is proper and within the law and applicable regulations. While it is recognized that certain types of treatment may be more sensitive in terms of the patient's privacy than others, it also has to be recognized by the patients and providers that when a Program is asked to pay for a substantial share of the bill, the Program is involved, despite the fact that this may conflict with a doctor's and patient's desire for total privacy and anonymity. The appealing party and the patient are is also reminded that CHAMPUS carefully guards all sensitive personal and medical information and has an impecable record on privacy. Hearings are closed to the public unless the appealing party deems otherwise. (While FINAL DECISIONS are indexed and by law must be made available to the public on request, no identifying names or geographic locations appear on the public copies.) (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER IV, Subsection A.5)

2. Burden of Evidence (Proof). CHAMPUS is committed to making an effort to obtain needed information and clinical records in order that a proper case review may be conducted. Beneficiaries and providers are counselled as to what is required

and the possible adverse impact that can result from a decision not to release records. Generally an appeal with such limited clinical information as was provided in this case would be remanded back to the Hearing Officer to obtain more information. That does not appear to be a reasonable alternative in this situation since both the appealing party and the beneficiary/patient have previously denied the Program access to requested information. Failure to provide sufficient evidence leaves no course but to continue to uphold the adverse findings that led to the hearing. (Reference: CHAMPUS Regulation DoD 6010.8-R, CHAPTER X, Section F, Paragraph 16.i.)

3. Participation in Appeal by Beneficiary/Patient. There is no indication from the Hearing File of Record that the beneficiary/patient in any way participated in, or contributed to, this appeal although she was made aware that the appeal was being pursued. The only information concerning the patient was the report by the appealing party that she had directed him not to release her records. The beneficiary/patient did not choose to join her clinical psychologist in filing and presenting the appeal. Had she done so, it is possible sufficient additional information could have been obtained to permit a more informed FINAL DECISION. As it is, the patient has no further administrative remedy for seeking payment of the psychotherapeutic services in dispute in this appeal.

4. Discrimination: Program Favored Medical Doctor. The appealing party indicated his concern that CHAMPUS extended its benefits in this case more on the fact that payments should go to medical doctors, instead of basing it on the fact that he, a clinical psychologist, was the primary psychotherapist. This assumption is in error. As indicated previously in this FINAL DECISION, the same standards were used in making a determination as would have been applied had the appealing party been a physician. The decision to reafirm the initial denial is based on the fact that there was insufficient clinical evidence to support a finding that the patient's mental condition was of such complexity and severity as to warrant two primary practioners providing concurrent essentially independent, individual psychotherapy, or that there was a crisis situation that required extensive and prolonged psychotherapy. Had the identical circumstances been present and the appealing party been a psychiatrist (as apposed to a clinical psyshologist), the outcome of this FINAL DECISION would have still been the same. The appealing party did not

provide sufficient evidence to support a finding that individual psychotherapy needed to be provided more than one primary practitioner regardless of the specific discipline of the therapist. It's the program's position that in any such situation the policy of first extending benefits for the services of the attending physician of record is a reasonable one.

RELATED ISSUE

Psychological Evaluation: 22 October 1977. The Hearing File of Record indicates that on 22 October 1977 the appealing party, in addition to the individual psychotherapy which is in dispute in this appeal, conducted a psychological evaluation (testing). The Hearing Officer did not comment on this item in his RECOMMENDED DECISION. However, it was the opinion of the Director, OCHAMPUS, that this evaluation was not a part of the issue involving Program limits for psychotherapy procedures and that this service qualified for benefits. The Principal Deputy Assistant Secretary of Defense concurs and will direct OCHAMPUS to make payment for this service.

SUMMARY

This FINAL DECISION in no way implies that the patient in this case did not require psychotherapeutic services. It only confirms that because of the absence of clinical information, neither the severity and complexity of her condition nor the existance of a crisis could be supported or confirmed; and therefore additional psychotherapy benefits, over and above those paid to the attending physicians, could not be considered.

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Our review indicates that the appealing party has been offorded full due process in his appeal. Issuance of this FINAL DECISION is the concluding step in the CHAMPUS appeals process. No further administrative appeal is available.

Vernon McKenzie
Principal Deputy Assistant
Secretary of Defense
(Health Affairs)