



ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

JAN 25 1985

HEALTH AFFAIRS

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

Appeal of )  
Sponsor: ) OASD(HA) Case File 84-48  
SSN: ) FINAL DECISION

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-48 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.3-R, chapter X. The appealing party is the CHAMPUS beneficiary, the spouse of a retired member of the United States Air Force. The appeal involves the denial of CHAMPUS cost-sharing for outpatient psychotherapy provided subsequent to May 30, 1982. The amount in dispute is approximately \$2,875.00 for the care as continued through November 1983.

The hearing file of record, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that CHAMPUS cost-sharing of the outpatient psychotherapy subsequent to May 30, 1982, be denied. The Hearing Officer found care was not medically necessary nor appropriate medical care and excluded from CHAMPUS coverage.

The Director, OCHAMPUS, concurs with the Hearing Officer's Recommended Decision and recommends its adoption by the Assistant Secretary of Defense (Health Affairs) as the FINAL DECISION in this appeal.

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 deny CHAMPUS cost-sharing of the outpatient psychotherapy provided subsequent to May 30, 1982, as not medically necessary nor appropriate medical care.

In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence in this appeal. The findings are fully supported by the Recommended Decision and the appeal record. Additional factual and regulation analysis is not required. The Recommended Decision is acceptable for adoption as the FINAL DECISION by this office. I do wish, however, to briefly summarize my rationale

for adoption of the Recommended Decision. Four peer reviewers, including three clinical psychologists and one psychiatrist, examined the medical records in this appeal during 1981-1982, and all separately opined the treatment plan for this beneficiary was inadequate for the diagnosis and length of treatment. Psychotropic medication was recommended by the reviewers to the extent that psychotherapy without medication should not continue. More than individual supportive/expressive psychotherapy was opined to be essential for the severe depression described in the case. Continued outpatient psychotherapy was recommended but not under the current treatment plan which had shown little progress since 1975. The unity of these opinions was persuasive to the Hearing Officer, and I concur in her evaluation.

A treatment plan, virtually unchanged for over seven years, deserves close scrutiny in view of the admitted slow progress of the beneficiary. A treatment plan which does not meet the needs of the beneficiary's illness is not medically necessary under CHAMPUS and cannot be cost-shared. The Hearing Officer, based on the medical reviews, reached this conclusion. I find her conclusion supported by the weight of the evidence in this appeal.

Further, the attending psychologist questioned the efficacy of medical reviews as evidence of the lack of medical necessity. As noted by the Hearing Officer, this office has found in previous Final Decisions that peer review, endorsed by the general medical community, is the most adequate means of providing information and advice to third-party payors. (See, e.g., OASD(HA) 06-80.) Through the hearing process, the beneficiary and provider have a full opportunity to submit all information they deem relevant to the care provided. A provider will not be heard to complain the medical reviewers lacked information where he is the primary source of the information and, as herein, failed to provide therapy notes, for example. The absence of documentation or testimony supporting the treatment falls upon the beneficiary/provider.

#### SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the outpatient psychotherapy provided subsequent to May 30, 1982, as not medically necessary nor appropriate medical care. The appeal and claims of the beneficiary are, therefore, denied. As the record indicates claims for outpatient psychotherapy were cost-shared during the period of May 30, 1982, through November 30, 1983, the Director, OCHAMPUS, is directed to consider recoupment of these erroneous payments under the Federal Claims Collection Act. Further, as the appeal record contains claims for outpatient psychotherapy only through November 1983, claims for psychotherapy provided subsequent to November 1983 must be reviewed for medical necessity in accordance with this FINAL DECISION. If claims are filed for outpatient psychotherapy provided subsequent to November 1983 and approved for cost-

sharing, the payments shall be offset against erroneous payments issued for care provided between May 30, 1982, and November 30, 1983. Issuance of this FINAL DECISION completes the administrative appeal process under DoD 6010.8-R, chapter X, and no further appeal is available.



Vernon McKenzie

Acting Principal Deputy Assistant Secretary

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

Appeal of	, Beneficiary )	<b>RECOMMENDED DECISION</b>
Sponsor:	)	
S.S.N.	)	
Provider:	, Ph.D )	

This is the Recommended Decision of CHAMPUS Hearing Officer, **SUZANNE S. WAGNER** in the CHAMPUS appeal case file and is authorized pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, Chapter X. The appealing party is the wife of a retired Air Force Technical Sergeant, and her claim is being represented by the Provider of psychiatric services, **Dr. Thomas R. Kraft**, a Psychologist. The appeal involves the denial of CHAMPUS cost-sharing for outpatient psychotherapy after May 30, 1982. As continuing care was involved, the amount in dispute as a result of the Formal Review Decision, issued December 6, 1983, stands (at least through November 1983) at \$2,875.50.

The Hearing File of record has been reviewed. It is the OCHAMPUS Position, as stated in the Statment of OCHAMPUS Position, issued April 13, 1984, that the Formal Review determination of December 6, 1983, denying CHAMPUS cost-sharing of the outpatient psychotherapy after May 30, 1982, should be upheld on the basis that the care in question provided after May 30, 1982, has not been documented to be medically necessary and appropriate care due to such limited progress over so long a period of time and the questioning of the efficacy of the therapy provided.

The Hearing Officer, after due consideration of the appeal record and the testimony concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing.

The Recommended Decision of the Hearing Officer, is therefore, to deny cost-sharing for the beneficiary's outpatient psychotherapy after May 30, 1982, because it was not documented to be medically necessary nor appropriate care.

**FACTUAL BACKGROUND:**

The beneficiary is the wife of a retired Air Force Technical Sergeant, and she has experienced a long history of anxiety and depression for which she sought emergency room treatment many times prior to December 1975. In December 1975, she began receiving outpatient psychotherapy from a clinical psychologist, Dr. Thomas R. Kraft. The psychologist, by 1982, was seeing the beneficiary once each week, and he was providing periodic progress reports indicating that slow progress had been made in her treatment. (Exhibits 8-10 and 13-14)

Subsequent to a peer review, the Fiscal Intermediary, Blue Cross and Blue Shield of South Carolina, informed the provider as follows:

"Payment thru May 30, 1982 to be approved, after which benefits will terminate. Peer reviewers feel no progress is being made and that a medical psychiatric consultation is needed. I am allowing 30 days to terminate."  
(Exhibit 3)

The Provider, requesting an Informal Review, provided a copy of a report of consultation by Clara Aisenstein, M.D., a psychiatrist. The report was dated April 10, 1982, and it stated, in part:

"In response to your request for a psychiatric consultation for insurance purposes, I saw [the beneficiary] for 50 minutes on May 25, 1982.

"Reason for Treatment: Mrs. [beneficiary] is currently in psychotherapy with you, her main complaint being depressed mood. She states that her depression is connected with problems in her marriage and her inability to make friends. In both situations she tends to feel exploited. She stated that her psychotherapy with you has been very helpful but that it has not solved all her problems and she wants to continue.

"Summary: We have here a middle aged woman with an inability to adapt to life situations due to a joyless existence filled with isolation, rejection, and a feeling of emptiness and dissatisfaction due to a

mixed personality disorder. That disorder, coupled with possible borderline intelligence, makes psychotherapy an arduous and prolonged process.

"Recommendations: I would strongly recommend that [the beneficiary] continue her psychotherapy with [the provider] since she has made slow but consistent gains in her years with him. Perhaps psychotherapy might be aided if we knew with more detail the extent of her intelligence so that a psychotherapy would have a more clearly cognitive and concrete slant. It would be important to rule out a beginning organicity. I would expect the process to take longer in her case than in the case of someone with a higher degree of intelligence and competence.

"I do not believe that mood modifying medication would be helpful in aiding the psychotherapeutic process. The patient herself resists this kind of intervention. Also, her limited intellectual capacity would make the administration of a M.A.O. inhibitor difficult as this is a complicated process on an out-patient basis." (Exhibit 4)

An informal review decision was issued by the Fiscal Intermediary on August 2, 1982, which upheld the denial of cost-sharing for outpatient psychotherapy after May 30, 1982. (Exhibit 6)

On August 16, 1982, the Provider requested a reconsideration of the denial of cost-sharing beyond May 30, 1982. (Exhibit 7)

On October 14, 1982, the Fiscal Intermediary issued a reconsideration decision to the Provider which stated, in part:

"On April 5, 1982, this claim accompanied the Outpatient Psychological Treatment Report and was submitted to our peer review. It was determined that although [the beneficiary] 'is making use of psychotherapy' the length of treatment, since December 1975, is excessive and unwarranted. Peer review suggests that medication be tried and/or another method of treatment or therapist be used. Peer reviewers felt that [the beneficiary] has a serious problem which should show more improvement at the state of her treatment if the treatment is appropriate. Although Dr. Aisenstein's consultation does not suggest another mode of treatment or medication since it was the unanimous opinion of our reviews that the length of treatment strongly indicates that different treatment should be tried, we must uphold the Informal Review decision." (Exhibit 8)

On November 10, 1982, the Provider wrote to OCHAMPUS requesting an

appeal of the reconsideration decision, and he stated, in part:

"[the beneficiary] feels that she has very definite psychological difficulties and feels she has made slow but definite steady progress.

"In my professional opinion, I see [the beneficiary] as a person who has severe and significantly intense emotional and psychological difficulties within herself, with her marital and family relationships, in her capacity for work, and in her social relationships... Psychotherapy seems to have lessened the extent of these crippling patterns but needs to continue therapy to make further progress for their resolution. As you may know these patterns are very difficult to break and treatment is usually long term in these types of cases. I have some serious question about the efficacy of medication for this neurotically based conflicts but I did agree to have a psychiatric consultation done to determine if medication was appropriate. Dr. Aisenstein's consultation and written report (Exhibit 4) indicated that medication was not recommended. If medication had been recommended by the medical consult, of course we would have followed a change in the treatment design for this patient; however, as stated it was not.

"...and I am concerned that if treatment cannot continue or perhaps had to be changed to another therapist which she does not want to do then it is possible that [the beneficiary] may again begin acting out her conflicts and some serious consequence may occur... My other concern is that before psychotherapy [the beneficiary] would get into severe confusional stress states and she would have to wind up in an emergency room requiring acute emergency medication for a few days." (Exhibit 9, pp.1-2)

On November 15, 1982, Dr. Clara Aisenstein sent a letter to OCHAMPUS supporting the provider's request for an OCHAMPUS First Level Appeal. In her letter, she stated, in part:

"I strongly support the continuation of treatment for [the beneficiary] by Dr. Kraft. I was dismayed to learn that the Board had determined that the treatment was unsuccessful because of its length... It is my feeling that she has been kept organized by her therapy with Dr. Kraft... Patients like [the beneficiary] superficially may appear slow, but the treatment is necessary to keep the patient from deteriorating." (Exhibit 10)

Exhibit 13 of the Hearing File contains hospital records from August, 1963, through November 15, 1982, noting various visits the beneficiary made to the hospital for physical and anxiety related disorders throughout

the years. The hospital records note that she was referred to the hospital on several occasions by the provider. (pp.1,2,7) The hospital records also reflect that on several occasions, while she was under the care of Dr. Kraft, she visited the emergency room complaining of symptoms of anxiety and depression (inability to sleep, chest pains, etc.) and asked to be seen by a psychiatrist. (pp.3,6,10,11) The hospital records also reflect that Valium was often prescribed for her symptoms.

As a result of the November 15, 1982, visit by the beneficiary to the Psychiatry Outpatient Clinic at Walter Reed Army Medical Center (Exhibit 13, p.1) and her evaluation by Dr. Eric A. Simmons, thereof, a report was sent to the provider by Dr. Simmons and Dr. Emmanuel G. Cassimatis, Chief Psychiatry Outpatient Service, regarding the beneficiary. The report by Drs. Simmons and Cassimatis stated, in part:

"2. Pertinent History: [the beneficiary] presented to Psychiatry Outpatient Clinic at Walter Reed Army Medical Center, 15 November 1982 for evaluation and possible follow-up care for her Depressive Symptomatology. She had been in long term insight oriented psychotherapy with Dr. Thomas Kraft since 1974. Since that time she has had no acute exacerbations of her illness requiring psychiatric hospitalization and has shown moderate increase of insight into her illness and how to control it.

"4. Diagnosis: DSM III Axis I Dysthymic Disorder 300.40. Axis III Borderline Personality Disorder 301.83

"5. Conclusions and Recommendations: [the beneficiary] is being treated with medication, (Norpramin, 150 mg. at bedtime) with some moderate improvement in her depressive symptomatology. She will continue to be followed at Walter Reed Army Medical Center, Psychiatry Outpatient Clinic for her medications. [the beneficiary] has benefitted from and could continue to benefit from insight oriented psychotherapy."  
(Exhibit 14)

Exhibit 14 also contains a letter from Dr. Kraft to OCHAMPUS, dated June 29, 1983, wherein Dr. Kraft explained that the beneficiary had sought the November 15, 1982 medical evaluation at Walter Reed Army Medical Center. Dr. Kraft stated, in part:

"...The medical check at this time was negative and as a result of the consult with psychiatry was placed on a trial of anti-depressant medication. At first she had serious side effects with significant weight



gain. With a change in medication she had a considerably better time in being able to sleep, with a minor but perhaps important improvement in mood. The slight improvement in mood has made it somewhat easier for [the beneficiary] to work in psychotherapy to alter her severe and incapacitating coping patterns. Although medication is acting as an aid, it does not replace the important and necessary need for [the beneficiary] to relearn coping strategies, with the aid of psychotherapy." (Exhibit 14 p.1)

Exhibit 15 contains Progress reports prepared by the provider with were submitted to three Peer Reviewers for their evaluation and the subsequent evaluation prepared by the latter. The provider stated that his goals for the beneficiary's treatment were:

"Psychotherapy for [the beneficiary] is geared to help her understand her self defeating behavior and to promote and reinforce more constructive and rewarding behavior that will return positive feedback. Focus on self concept and self image to reverse the neurotic masochistic pattern. I expect 100-200 session hard to estimate." (Exhibit 15 p.3)

"Therapy is oriented toward helping [the beneficiary] to modify her masochistic surrenders in relationships, to better care for herself and thereby help relieve the depressive and anxious symptoms." (Exhibit 15 p.9)

Excerpts from the Peer Reviews, received by OCHAMPUS on April 19, 1982, stated, in part:

"...From the therapist's own description, it would not appear that the current therapy is appropriate... the therapeutic approach seems to continue to be very fuzzy... there is no clear progress indicated or described by the therapist... no progress is evidenced... Medical/psychiatric consultation is clearly indicated in this case. Adjunctive chemotherapeutic therapy certainly seems at least a possible addition. This therapist does not seem to recognize the severity of the problems this patient evidences." (Exhibit 15 p.4)

"Psychiatric evaluation for medication essential. Discontinue therapy if no evidence of reasonable progress is forthcoming." (Exhibit 15 p.5)

"A number of reviewers have suggested that the type of therapy is not appropriate. I agree, especially since there has been little progress from 1975 when therapy began... this patient needs more than individual supportive/expressive therapy. A program needs to be established on how to work with her in other places that the therapy hour... Certainly consultation is needed, psychiatric and other. The therapist needs

help in understanding this patient's condition and in developing a program, other than just individual therapy, to influence and work with her. Neither supportive or insight therapy alone will lead to meaningful changes." (Exhibit 15 p.6)

"Provider continues to describe severe depression which may be amenable to some form of psychotropic medication... Based on the information I have available to me, I question the appropriateness of the therapy and see as absolutely essential a psychiatric consultation for evaluation for medication. Patient does not appear to be making reasonable progress, and I have no information which would suggest a way that the patient may be more helped." (Exhibit 15 p.7)

"Continuation of treatment is warranted, but the patient needs a more direct and a more encompassing approach. The therapist should be urged to get some consultation about this case with the intention of setting up a treatment program that will do more than help the patient maintain her present condition. This is the kind of case that needs more than individual 'supportive/expressive psychotherapy'..." (Exhibit 15 pp. 10-11)

"...Provider's goals are ill-stated and not at all specific or concrete. One gets the impression from provider's narrative that he has little if any goal for the patient but is going along with her on a catch as catch can basis, giving her what support he can, and hoping that she will improve. I do not see this as adequate psychotherapy..." (Exhibit 15 P.12)

"Unfortunately, this patient is not receiving the assistance she needs in dealing with and eventually overcoming her rather severe emotional problems. The therapist describes a patient with probably a borderline personality disorder accompanied by serious self-destructive tendencies. While the symptomatology no doubt interferes with the patient's current functioning both personally and in her work, it is of a longstanding nature and needs to be dealt with as such... The inadequacy of the therapist's goals give evidence of his/her lack of understanding of the seriousness and nature of the patient's problems. By the therapist's own description this patient is seriously disturbed, close to and capable of breaks with reality, and in need of intensive, in-depth therapy. Since the current therapist has not perceived this need, this patient should be terminated within three additional sessions and referred to another therapist for treatment. Psychiatric consultation relative to the potential for chemotherapeutic adjunctive therapy is also indicated." (Exhibit 15 pp. 14-15)

The progress reports from the Provider, his letters, the letter from Walter Reed Army Medical Center and the letters from Dr. Aisenstein,

the psychiatric consultant, were submitted to the Medical Director of OCHAMPUS for his review, and on November 9, 1983, he issued his Memorandum. Dr. Rodriguez, a psychiatrist and the Medical Director of OCHAMPUS, stated, in part:

"Three separate psychological reviewers of the American Psychological Association independently reached the same conclusion in April 1982 that this provider had not adequately provided information that would justify continuing care. None of the reviewers were indicating that this beneficiary was not in need of outpatient psychotherapy...The other reviewers were more specifically concerned about the services provided by this provider, specifically raising some questions about the adequacy of this provider to engage the beneficiary to the level where a certain level of progress would ensue. They do raise some question about the adequacy of the treatment plan, the appropriateness of the therapeutic approach, the need for the therapist to better understand the patient's condition after seven years and to develop an adjunctive program of support outside the individual psychotherapy programs, and, in general, raised a question about the adequacy of the evaluation over time by the provider...

"I support the contentions made by the peer reviewers... We have a letter dated June 14, 1983 from Drs. Simmons and Casamatis from the psychiatric outpatient service at Walter Reed Army Medical Center that indicates... On November 15, 1982, this beneficiary spontaneously presented herself at the outpatient psychiatric clinic for evaluation and followup care for a depressive symptomatology characterized by anxiety, crying spells, early morning awakenings, and feelings of hopelessness on awakening. .. it had been somewhat long-standing... This beneficiary had experienced significant symptomatology for a number of years that was not adequately evaluated or treated.

Drs. Simmons and Casamatis state "Mrs. [beneficiary] is being treated with medication with some moderate improvement in her depressive symptomatology... Mrs. [beneficiary] has benefitted from and could continue to benefit from insight-oriented psychotherapy.' Now that she is on medication, she may indeed be benefitting from the psychotherapy... a key serious omission in the treatment of the beneficiary occurred by one psychologist and a consultant psychiatrist... I would consider that the care is not medically necessary..." (Exhibit 17 pp.1-2)

In answer to the question, "Does the record establish that the outpatient psychotherapy from December 1975 to May 1982 was medically necessary?",

Dr Rodriguez replied, in part:

"The record does establish that outpatient psychotherapy was needed and was provided... It's only following the April 1982 peer reviews that we raise questions about the continuing medical necessity... [after May 30, 1982] the care was no longer medically or psychologically necessary. That is, the care was not specific or required for the evaluation or treatment of this beneficiary who might have needed continuing outpatient psychotherapy but not from this provider. The appropriate level of care was the outpatient level, and that should have ensued with a provider who was better able to meet the specific therapeutic needs of the beneficiary. Specifically, these were a combination of medication and a program outside of the specific supports provided in the psychotherapy sessions, that is some environmental manipulation... The focus of this therapist was solely supportive and insight-oriented with the individual. The therapist should have some active role in manipulating the environment, recognizing the stressors being relatively constant and that this individual, because of limited intelligence and limited psychological insight, was not able to solely manipulate her own environment.

"...It appears the provider was not perceptive or able to provide the other kinds of treatments that were needed such as medication... Dr. Aisenstein's only justification for not allowing that this beneficiary needed medication was not based on signs and symptoms..., but her basis in fact is because this beneficiary lacks insight, lacks intelligence, and lacks the will 'perhaps' to take the medication. Yet, that is defied by this woman's seeking out medications and taking them consistently for a period of eight months."  
(Exhibit 17 pp. 2-3)

In response to the question, "On what do you base your statement that she had had symptoms of depression for a long period of time?", Dr. Rodriguez stated, in part:

"Her depressive symptomatology, upon which the diagnosis of depressive neurosis had been made was as far back as 1975. The Mental Illness Treatment Reports periodically mention such symptoms as trouble sleeping and weight problems. She was experiencing physical evidence of a biological depression for several years that was never adequately evaluated or treated. I think we're being quite judiciously liberal in allowing care through April 1982, and so do the peer reviewers.

"For this provider to contend that this care can be justified in simply not borne out by the record or by the course of treatment... This is not an issue

where he can contend that the standards related to progress are indefinite, ambiguous, or vague, and I think any consensus by any body would contend that, as borne out by the subsequent course of this woman's seeking medical care." (Exhibit 17 pp. 3-4)

Dr. Rodriguez ended his Memorandum by stating:

"What we've substantiated is that she needed treatment from somebody but not this provider. I'm sure his care was empathetic, caring, and attentive, but it was not thorough."  
(Exhibit 17 p.4)

On November 25, 1983, Dr. Kraft wrote to OCHAMPUS requesting to be informed of the status of the appeal. (Exhibit 18) On December 6, 1983, a Formal Review Decision was forwarded to Dr. Kraft denying cost-sharing for outpatient psychotherapy beyond May 30, 1982, on the basis that the treatment provided by the provider was not medically necessary. (Exhibit 19)

On January 20, 1984, OCHAMPUS received a letter from the beneficiary requesting a Hearing. (Exhibit 20) On January 29, 1984, Dr. Kraft sent a letter to OCHAMPUS disagreeing with the Formal Review Decision and requesting a clarification as to the amount of cost outstanding to the beneficiary. (Exhibit 21)

On March 14, 1984, a letter was sent to Dr. Kraft advising him that the request for a Hearing was accepted. (Exhibit 22) On March 30, 1984, the undersigned Hearing Officer sent a Notice of Hearing to Dr. Kraft and the beneficiary by Certified Mail.

The Hearing was held on Monday, May 7, 1984, beginning at 8:45 A.M., in a conference room at the Department of Agriculture Building, 14th and Independence Avenues, S.W., Washington, D.C., and those present were the Hearing Officer; the OCHAMPUS Attorney-Advisor, Mr. William Voharis; the beneficiary; the Provider, Dr. Thomas R. Kraft; and Dr. Duane Riddle, a psychologist who testified as an expert witness for Dr. Kraft.

At the Hearing, the Attorney-Advisor for OCHAMPUS placed into evidence the OCHAMPUS Statement of Position accompanied by the Statement of Alez R. Rodriguez, M.D., the OCHAMPUS Medical Director, in the Matter

of [the beneficiary] and an excerpt from the Final Decision OASD(HA) 06-80 regarding the Challenge to Peer Review. These documents were entered into the record by the undersigned Hearing Officer as Exhibit 23. The Statement of OCHAMPUS Position, which concluded that:

"...the care in question provided after May 30, 1982 has not been documented to be medically necessary and appropriate care due to such limited progress over so long a period of time and the questioning of the efficacy of the therapy provided. The care therefore is not eligible for CHAMPUS cost-sharing."  
(Exhibit 23 p.4)

relied on the Peer Review and Medical Opinion of the OCHAMPUS Medical Director in reaching the determination to deny cost sharing after May 30, 1982. The concerns of the Peer Reviewers regarding the treatment of the beneficiary by the Provider were summarized in his November 9, 1983 Memorandum ((Exhibit 17 hereinbefore quoted on pages 8-10 hereof)

Attached to the Statement of OCHAMPUS Position (Exhibit 23) is a Statement of Alex R. Rodriguez, M.D. in the Matter of [the beneficiary] wherein he reviewed his prior Medical Opinion (Exhibit 17) in view of the facts presented in Dr. Kraft's letter of January 29, 1984 (Exhibit 21). The OCHAMPUS Medical Director stated:

"I have reviewed Exhibits 17 and 21:... I do find that the statements provided by him [the provider] do not add anything substantially to the clinical information that has been previously reviewed. It would not cause me to alter any of my opinions. Specific comments related to his contention that in my position as Medical Director, I have rendered opinions for, included the need for consideration as medication, environmental manipulation, and marital therapy. Dr. C[K]raft says these interventions were carefully considered along with progress of the therapy and were all tried. They may have been tried in various times in the course of her treatment and maybe with variable success. We found a record substantiated by APA reviewers that seriously raised questions about the combination of these approaches, the length of these approaches, or the coordination with his individual psychotherapy. In fact, it appears that Dr. C[K]raft was solely banking, at this time after May 1, 1982, on his treatment which was predominantly outpatient supportive, or insight psychotherapy. I would underscore that with any individual continuous and ongoing therapy attempts should be made with such a significant disorder as this for environmental manipulation or any other adjunctive treatments that may potentiate or assist the individual psychotherapy. The main contention here, however, made by the APA reviewers, in which I find that I must concur, is that they were questioning

the capacity of this provider through the formation and management of the therapeutic alliance to promote change, i.e., a therapeutic process, in the psychotherapy he provided to her. There is simply so limited progress, over a considerable period of time we can say that there was no substantial change, and therefore there must be some question of the efficacy of psychotherapy provided by this provider to this beneficiary to effect the desired aim..." (Exhibit 23 p.2 of Statement of Alex R. Rodriguez, M.D.)

Mr. Voharis, in summarizing the OCHAMPUS Position, emphasized that it was not solely the length of treatment which was the basis of the denial of cost-sharing after May 30, 1982. He pointed out that the components of the denial were: the length of treatment with so limited progress; the lack of environmental manipulation in terms of dealing with job, family or activities to help enhance the beneficiary's self-esteem; the refusal to use medication in the treatment of the beneficiary. It was also noted by Mr. Voharis that Dr. Kraft argued that the Peer Reviewers and Medical Director's opinions should be discounted somewhat because they did not have any personal contact with the beneficiary on which to base their opinions. Mr. Voharis pointed out that:

"It has been long held by OCHAMPUS and has appeared in precedential decisions of the Assistant Secretary of Defense for Health Affairs that Peer Review is accepted by the general medical community as the best way for a third party payor to decide on claims, and also that the Provider's statements on the care of the patient is not necessarily controlling."

In support of this statement, Mr. Voharis introduced OASD(HA) Final Decision 6-80, paragraph # 6 (Exhibit 23). Also, Mr. Voharis introduced into evidence the professional qualifications of Dr. Alex R. Rodriguez. (Exhibit 24)

Dr. Kraft, before presenting his testimony, asked for a clarification of the confidentiality of the record. Mr. Voharis explained the procedures followed by OCHAMPUS with regard to maintaining confidentiality of the record. Dr. Kraft also submitted his Curricula Vitae and a reading list for a course which he teaches to be placed into the record (Exhibits 25 and 26 respectively) He also stated that he teaches graduate level courses at American University dealing with the Borderline Personality.

Dr. Kraft responded to the OCHAMPUS Position that the treatment program

for the beneficiary was insufficient by April 1982. Dr. Kraft noted that the OCHAMPUS Position specifically raised objection to the fact that medication therapy had not been considered and was thought not to be necessary. He also noted that the OCHAMPUS Position referred to the beneficiary as suffering from symptoms of vegetative depression which would indicate the need for a trial of antidepressant medication. Also, Dr. Kraft noted that the OCHAMPUS Position based the need for antidepressant medication on the fact that drug therapy was of value because it was instituted by the psychiatrist at Walter Reed and that it had shown some moderate improvement in the beneficiary's symptomatology. It was on these bases that Dr. Kraft testified his evaluation and treatment of the beneficiary was called into question.

Specifically, Dr. Kraft testified first as to the spontaneous presentation by the beneficiary to the Psychiatric Outpatient Clinic at the Walter Reed Army Medical Center for depressive symptomatology on November 15, 1982, as referred to by the Medical Director of OCHAMPUS in his November 9, 1983, medical opinion (Exhibit 17).. Dr. Kraft, in support of his position that his evaluation and treatment of the beneficiary were medically necessary and appropriate medical care, referred to the June 14, 1983, letter from Drs. Simmons and Cassematis at Walter Reed (Exhibit 14 pp. 3-4), wherein there is no discussion as to the acuteness or chronicity of the beneficiary's depressive symptoms, and, wherein, it is stated that she "has benefitted from and could continue to benefit from insight oriented psychotherapy." Dr. Kraft again quoted from this letter wherein it was stated that as a result of her long term psychotherapy with Dr. Kraft:

"She has had no acute exacerbations of her illness... and has shown moderate increase of insight into her illness and how to control it."

Dr. Kraft pointed out that this opinion from Drs. Simmons and Cassimatis of Walter Reed differs significantly with the opinions of the Peer Reviewers and Medical Director of OCHAMPUS. He added that Dr. Aisenstein, in her consultation report (Exhibit 9 p.8) stated:

"...she has made slow but consistent gains in her years with him [the therapist]."

Dr. Kraft also referred to Dr. Aisenstein's remarks that the progress of the beneficiary may be limited by the latter's low intelligence;



that some aspects of the beneficiary's depression stem from her neurotic conflict and her masochistic predisposition, and that the beneficiary gained from her therapy an awareness of some mechanisms of intrapsychic behavior (such as, "her need to gain approval from others which could be so intense that she would subject herself to humiliation").

In reference to Dr. Aisenstein's letter of November 15, 1982, (Exhibit 10), Dr. Kraft quoted:

"I concur with Dr. Kraft that [the beneficiary] is seriously ill with Borderline Personality Disorder. It is my feeling that she has been kept organized by her therapy with Dr. Kraft... Patients like [the beneficiary] need prolonged treatments."

Dr. Kraft then referred to the Medical Opinion of Dr. Rodriguez (Exhibit 17 p.3) and quoted from the latter's answer to question #1, wherein it is stated:

"Dr. Aisenstein's only justification for not allowing that this beneficiary needed medication was not based on signs and symptoms (she does not mention that in her statement and I find that a terrible oversight), but her basis in fact is because this beneficiary lacks insight, lacks intelligence, and lacks the will 'perhaps' to take the medication. Yet, that is defied by this woman's seeking out medication and taking them consistently for a period of eight months."

In response to this statement, Dr. Kraft again referred to Dr. Aisenstein's consultation report of June 10, 1982, (Exhibit 9) where she stated:

"I do not believe that mood modifying medication would be helpful in aiding the psychotherapeutic process. The patient herself resists this kind of intervention. also, her limited intellectual capacity would make the administration of a M.A.O. inhibitor difficult as this is a complicated process on an out-patient basis."

Also, as to the beneficiary's presenting herself at Walter Reed Army Medical Center on November 15, 1982, Dr. Kraft testified that it was his understanding that the beneficiary went to that facility for the purpose of getting a physical check-up regarding the condition of her thyroid. The thyroid test was negative, and the examining physician asked the beneficiary about her energy level and the state of her nervousness. Dr. Kraft and the beneficiary testified that the latter explained to the examining physician that she was seeing a psychologist for therapy, but that these visits might be stopped because of the

termination of CHAMPUS benefits. She was then asked if she wanted to see a psychiatrist at Walter Reed, and she thereupon was seen by the psychiatric resident at Walter Reed. It was understood by the psychiatric resident and the beneficiary that the latter was to continue to see Dr. Kraft for psychotherapy sessions. Dr. Simmons prescribed the medication for the beneficiary primarily to aid the latter to sleep. Dr. Kraft testified that he supported the beneficiary's continued taking of the medication due to the concern by OCHAMPUS Peer Reviewers that she be given a trial of antidepressant medication.

Dr. Kraft testified that his initial diagnosis of the beneficiary, as listed on the insurance form was Depressive Neurosis, which diagnosis was made when the DSM II was in operation. Her depressive symptoms sometimes had vegetative signs such as her difficulty in sleeping. Her depression was also documented to be associated with emotional crises and anxiety relating to major upsets in her interpersonal relationships and family life. Dr. Kraft then referred to the documentation of the situational or reactive depression as being found in the record of her visits to the hospital for anxiety related symptoms: August 9, 1966, May 7, 1973, April 2, 1976, July 2, 1979, November 8, 1980, and November 19, 1980. (Exhibit 13). Dr. Kraft testified that on all of these occasions, she was treated for reactive depression or anxiety symptoms. There are also two letters contained in Exhibit 13 whereby Dr. Kraft referred the beneficiary to Andrews Airforce Base for medication for anxiety and depression target symptoms.

In his testimony, Dr. Kraft stated that he is not opposed to medication for depression, and that he treats many patients who are taking antidepressant medication. He stated, however:

"It is my position, and it has been all along, that this patient's depressive symptoms -- that with this patient's depressive symptoms, she has had a serious -- uh -- personality problems, and with the advent of the DSMIII, the request for more detailed descriptions on insurance forms and Peer Review, this patient's diagnosis, as I would list it, included, then some of her borderline problems under the label of Borderline Personality.

"My diagnosis of the Neurotic Depression, DSMII, in a mixed personality disorder, has been consistently observed and reported by all psychiatric doctors that

have seen [the beneficiary]. Dr. Simmons' reports show the diagnosis in DSMIII to be: Axis I Dysthymic Disorder; Axis II Borderline Personality Disorder. This patient's depression is associated with and secondary to her Borderline Personality make-up."

Dr. Kraft distinguished between the reactive depression suffered by the beneficiary which he stated is secondary to her Borderline Personality Disorder and a patient showing signs of a vegetative depression associated with an endogenous type of depression which does not usually show itself to be associated with various precipitating stressors. He pointed out that all of the depressive symptoms exhibited by the beneficiary have been associated with and reactive to upsetting events or relationships in her life.

Dr. Kraft testified that it is standard practice to treat neurotic depression with psychotherapy, and he cited Leo E. Hollister, M.D., clinical Pharmacology of Psychotherapeutic Drugs, Second Edition, 1983 (Exhibit 28) tables 4.1 and 4.2 as authority for his determination that the beneficiary did, indeed, suffer from reactive depression as opposed to an endogenous depression. Reactive depressions, such as Dr. Kraft contends is suffered by the beneficiary, is said, in the Hollister text, to be responsive to a variety of ministrations, and that it does not, in contrast to an endogenous depression, respond specifically to antidepressants.

Dr. Kraft explained that the DSMIII Dysthymic Disorder is the same as the DSMII Depressive Neurosis diagnosis. He testified that there is a possibility that the record of the beneficiary may be somewhat confused because the diagnostic systems have changed during the treatment of the beneficiary. Dr. Kraft referred to Anreassen, N. "Concepts, diagnosis and Classification" in Handbook of Affective Disorders, Ed. by Paykel, 1982 Guilford Press, N.Y. -- wherein it was reported that the DSMIII classification uses the term with melancholia to refer to endogenous depressions. He testified, referring to the authorities cited in "References" (Exhibit 27), that most studies have explored that dichotomy between endogenous and neurotic depressions. Dr. Kraft explained that "neurotic" carries multiple meanings with it such as:

"'A disorder arising from internal psychological conflict, a disorder which is characterised primarily by anxiety, a disorder which is likely to be chronic and mild, or a disorder which is to be treated with psychotherapy rather than medication.' Page reference is 37."

Dr. Kraft stated that the beneficiary has never been seen to show signs of a major depression DSMIII, which would be more responsive to medication. He stated that the beneficiary, who carried a dual diagnosis of Dysthymic Disorder and Borderline Personality Disorder, must be viewed according to the DSMIII (on page 222), which states:

"'Often the affective features of this disorder, the Dysthymic Disorder, are viewed as secondary to an underlying personality disorder and should be labelled as such.'"

Dr. Kraft continued, that to understand how the two diagnoses (Dysthymic and Borderline Personality Disorders) may be associated in certain individuals who show a borderline structure to their personalities, one should refer to (Exhibit 27) Meissner, W. The Borderline spectrum: Differential Diagnosis and Development Issues, 1984, Aronson, N.Y. Meissner refers to the Dysphoric Personality, and says"

"'The Dysphoric Personality represents a transitional form of character pathology between the lower order borderline conditions and the higher order borderline conditions. Medication is of little use in the long term management of such patients. Medications, however, may help with target symptoms. Neuroleptics, in low doses, may help manage regressive crises especially where self-fragmentations and delusions enter the picture. Valium or other tranquillizers, on an intermittent basis, can, at times, ease patients through difficult periods. My own experience does not suggest that antidepressants are ever of much help.' Page number 197."

Dr. Kraft stated that before beginning treatment with him, the beneficiary did, on several occasions, go to the Andrews Airforce Base Hospital and get medication to help with her target symptoms. Dr. Kraft stated that OCHAMPUS has argued that since the beneficiary suffers from a Dysthymic Disorder that she should be treated with antidepressant medication, that it appears that she was not treated with medication, and that the psychotherapy, since its institution in 1975, was not medically necessary or appropriate. Dr. Kraft testified that it is his contention that the beneficiary's Dysthymic Disorder is linked and associated with her character-personality problems and that therefore the psychotherapy she has been receiving since 1975 is medically

necessary and appropriate care.

Dr. Kraft testified, again, that on several occasions he referred the beneficiary to the hospital to receive medication for her target symptoms. He added that she has shown some moderate improvement in sleeping since she began on the medication in November, 1982, but that the depressive features connected with her characterologically based borderline personality continue to need to be addressed by psychotherapy.

Dr. Kraft then testified that he spoke by telephone with Dr. Bastiar, the psychiatrist whom the beneficiary sees at Walter Reed for her medication, on May 1, 1984, and that he was assured by Dr. Bastiar that the psychotherapy of the beneficiary with the former was fully supported as the primary treatment. Dr. Kraft stated that Dr. Bastiar assured him that the medication treatment was considered to be secondary and peripheral to the psychotherapy. Dr. Kraft also testified that the beneficiary was seen by Dr. Bastiar in the medication clinic, and that she would not be able to be seen at Walter Reed by a therapist at the frequency she required. Also, he testified that on occasions that the beneficiary was unable to sleep, she sometimes doubled her medication on her own with poor results. The provider stated that this was one of the problems with medication which he and Dr. Aisenstein feared.

At this point, Dr. Kraft testified as to the psychological testing results of the beneficiary. On the "Wais," she tested in the low average I.Q. area. Because of her limited abilities, her ability to make gains from therapy may be limited and her progress may be slow. The beneficiary was culturally deprived, benefitted little from schooling, and a member of a racial minority -- all of which factors may have bearing on the slowness of her progress in therapy. Dr. Kraft did again state that all clinicians who have seen the beneficiary have stated that she has benefitted from her therapy with him.

Dr. Kraft cited studies which have shown that even though there were more drop-outs from psychotherapy in the low I.Q. patient range, that the patients of that category who remained in therapy did as

well as the middle class patients. (Frank, J., Gleidman, Imber, Nash, Stone. "Why Patients Leave Psychotherapy." Arch. of Neurology and Psychiatry. 1957 77, 283-299).

The test results also were germane to the evaluation and diagnosis of the beneficiary. Dr. Kraft referred to the MMPI (Minnesota Multiphasic Personality Inventory) (Exhibit 29) He used this test result in conjunction with an article by Resnick, R., Schulz, Schulz, Hamer, Friedel & goldberg, "Borderline Personality Disorder: Symptomatology and MMPI Characteristics," Journal of Clinical Psychiatry 44: 289-292, 1983, wherein the broken line scale on page 1 of the MMPI (Exhibit 29 p.1) represents the profile of the borderline group as described in the article. The solid line represents the beneficiary's profile. He pointed out that the beneficiary's profile shows a typical borderline personality with the highest elevation on the 4p.d. scale. Also the 6 scale pa and the 8 scale sc showed pathological elevations. The depression scale, 2D, also showed an elevation and it was in close proximity to the 6 scale pa which indicates anxiety levels. Dr. Kraft testified that MMPI indicates that the beneficiary has a significant characterologically based disorder, a borderline personality, as she primary pathology and that she shows some depression as an associated symptom.

Dr. Kraft stated that the Rorschach test results of the beneficiary indicated that she has some minimal signs of depression such as low self evaluation, but that she does not have any of the other major indices of a major depressive syndrome including morbid content, major shading, etc.. Her reality tests were within the normal range. The Bender - Gestalt showed no signs of any CNS organic dysfunction in the individual areas. (Exhibit 30). The AATAT, the thematic apperceptive test, in contrast to the Rorschach, showed that the beneficiary does get sad as a result of her interactions with others, thereby demonstrating the reactive nature of her depression. The provider stated:

"She generally expects bad outcomes when she has to deal with others in relationships."

With respect to the issue of providing more directed therapy, environmental manipulation, and marital therapy, Dr. Kraft testified that he had seen the husband of the beneficiary twice in the office, but that neither the beneficiary nor her husband were willing to participate

in marital therapy. He testified that he has consistently encouraged the beneficiary to seek employment and has given her direction in this regard, but that she has difficulties with relationships and has been unable to work on a regular basis. The beneficiary is on a government disability, but Dr. Kraft testified that the obtaining of regular employment by the beneficiary is a goal on which they are working.

Dr. Kraft next testified as to the statement in the Medical Opinion of Dr. Rodriguez which accompanied the OCHAMPUS Statement of Position, wherein it was stated, in part:

"The main contention here, however, made by the APA reviewers, in which I find that I must concur, is that they were questioning the capacity of this provider through the formation and management of the therapeutic alliance to promote change, i.e. a therapeutic process, in the psychotherapy he provided to her." (Exhibit 23)

Dr. Kraft questioned what was meant by such "alliance" inasmuch as he felt that he and the beneficiary worked well together and had developed goals for therapy. He questioned the amount of change that was expected by OCHAMPUS to occur for this patient given her diagnosis, history, life circumstances and other limiting factors. He stated that the goals which were expected by the Peer Reviewers for the normative patient may differ substantially from the goals which are achievable with this particular patient.

Dr. Kraft stated that he was afforded the Peer Review Opinions after the OCHAMPUS review process had begun. He stated that if he had had the Peer Review Opinions earlier, he would have had the opportunity to consult with the Peer Reviewers as to the appropriateness of their recommended treatment methods.

Dr. Kraft maintained that some of the assumptions made by the Peer Reviewers were based on Progress Reports which did not contain all of the information necessary to formulate the opinions reached by them. He maintained that it is not possible for the Peer Reviewers to be privy to all of the information to which the therapist has access

such as information regarding the marital relationship of the beneficiary and other information which was of a confidential nature. The concern of the therapist provider regarding confidentiality of the reports required of him was exemplified by the statement in one of the peer reviews, wherein the reviewer noted:

"LEVEL II REVIEWER PLEASE NOTE:

This narrative was not completely sterilized. The patient's name appears in Part IV, as circled in red."  
(Exhibit 15 p.15)

Dr. Kraft summarized as follows:

" I have provided appropriate and medically necessary care in the form of psychotherapy, and with consultation, and have supported medication when I thought it was necessary and appropriate. My position is further supported by the evidence I have provided including support from the literature reference reports, further data and information about this patient, psychological test support, confirmation by other psychiatric professionals -- 3 psychiatrists and one other psychologist -- all who have had clinical contact with this patient -- to provide their opinion of the correctness of the diagnosis and treatment program. These assessments are also in accordance with the doctors that have seen [the beneficiary] in the emergency room before I began treatment with her. It is well known fact that some patients show a very chronic pattern to their illness... the question of progress, I would like to raise whether an appropriate treatment goal would be to further prevent any decompensation as well as any deterioration in their marital relationship that would either lead to divorce or possible major psychiatric hospitalization. This patient has worked hard in her life, has done the difficult task of raising three children -- and rather successfully I might say... she has also worked for a number of years for the government, has done well in that regard. By virtue of benefits being terminated for [the beneficiary] she has reluctantly had to reduce her therapy with me to once a week [sic -month]. Clearly she needs more help and contact than this..."

Mr. Voharis asked whether the therapy for the beneficiary was court ordered. Dr. Kraft said the treatment was court supported, but not court ordered. He then asked Dr. Kraft about the usefulness of group therapy for the beneficiary. Dr. Kraft answered that he advocated the use of group therapy, but that the beneficiary was not at a point, yet, where she could cope with group therapy. Dr. Kraft said that group therapy would be useful to the beneficiary when she had a better view of herself.



Mr. Voharis asked specifically about environmental manipulation, and Dr. Kraft said that he had utilized some kinds of environmental manipulation; i.e. suggested jobs, wrote letters regarding her legal problems, saw her husband twice and saw her daughter once. Dr. Kraft also stated that family therapy would not be useful now as the family was dispersed at this point.

When asked about termination goals for this beneficiary, Dr. Kraft stated that this issue was complex. He did state that she now has the ability to pull out of pathological relationships, and that his goal was for her to gain better friends, to attain a degree of independence in the marriage, and to sustain some sort of employment. The goal is to get the beneficiary to the point where she can sustain her independence and thereby resolve the marital conflicts with which she lives. Dr. Kraft stated that, with the help of therapy, she should be able to resume some kind of employment, and that as her ability to support herself increases, she should be able to resolve the marital difficulties.

The beneficiary testified that she was referred to Dr. Kraft by Dr. Giraldo at Andrews Airforce Base Hospital. She stated that she had been crying, that her hands tightened and that she had fainting spells -- and these were the symptoms which caused her to seek help. She testified that it was family problems and marital problems which have caused her to continue with therapy. She stated that she trusts Dr. Kraft, that her therapy has helped her with her problems in that she could talk out her problems with him. She testified that she does not talk to the psychiatrist at Walter Reed or get therapy from him -- that she sees him only for the purpose of getting her medication. She testified that the medication only helps her to sleep -- that it is the therapy that helps her to cope with her problems. She stated that she now is able to go to Dr. Kraft only once each month, and that she needs to see Dr. Kraft more often than this.

The beneficiary reiterated that she went to Walter Reed for a physical to determine if her thyroid was all right, that the test was negative, that because CHAMPUS terminated her benefits, she needed some help, and that she went to the psychiatrist at Walter Reed because she couldn't afford to see Dr. Kraft as often as she needed. She testified that

when she was seeing Dr. Kraft once a week, she did not feel the need for medication, but that she needed something to help her since her therapy had been curtailed. She again stated that the medication helped her only in so far as sleeping. She also stated that Dr. Simmons (at Walter Reed) told her that he was only giving her medication and that she should continue her therapy with Dr. Kraft. She testified that her husband was asked to participate in marital therapy, but that he refused. She also stated that she is unable to work because her hand was injured on a job and because she can't get along with the public. She stated, "People ride me" -- and she explained that she was unable to get away with things that everyone else could; i.e. like coming into work late, that she got all the hard cases, etc..

The beneficiary testified that Dr. Kraft has always been supportive of her working, and that she does not feel that she functions well enough now to get along without therapy. She stated that she wants to continue therapy with Dr. Kraft, that she would change therapists if she had to, but that she trusts Dr. Kraft and wants to stay with him. She also stated that when she was under the care of Dr. Geraldo, she went to group therapy a few times, but that she was unable to get along with the group.

The beneficiary, throughout her testimony, emphasized that she did not feel the need to take medication on a regular basis when she was seeing Dr. Kraft for regular seekly sessions. She stated that it was the termination of her benefits which caused her to reduce her sessions with Dr. Kraft which resulted in her becoming overwhelmed by nervousness and anxiety; and that she then sought help from the psychiatrist at Walter Reed. She reiterated several times that the medication she received from the psychiatrist helped her only to sleep, and that it was her sessions with Dr. Kraft which helped her to cope with the stressors in her life. She stated that she does not feel ready to face the stresses which she confronts in her life without the aid of her therapy with Dr. Kraft.

Dr. Duane Riddle, a clinical psychologist who saw the beneficiary twice in consultation, testified on behalf of Dr. Kraft in support of the latter's evaluation and treatment of the beneficiary. He explained that in his initial session with the beneficiary, he focused on understanding the problems of the beneficiary as she viewed them; and in the second session, he focused on an evaluation of her condition. He testified that, after his initial session with her, he found her to be pleasant, and he found that her therapy with Dr. Kraft had been supportive and insightful. He then stated that he wanted to look into her level of ability and her emotional dynamics.

Dr. Riddle, in his second session with the beneficiary, readministered some of the subsections of the Wais Sub R Test. He found that in the similarity sub-tests, her testing was somewhat higher than on the original Wechsler Intelligence Testing. "Low average" is descriptive of the intelligence testing result which Dr. Riddle administered. He also described other testing, and stated that her reality testing was appropriate, that there was no indication which would support a major depressive diagnosis, and that there was some mental vitality in an ability to integrate. Because of these findings, Dr. Riddle stated that he was more assured that her Wais - R sub test result of "6" was fairly accurate and a conservative estimate.

Dr. Riddle stated that the MMPI results (Exhibit 29) indicated that there was some depressive symptomatology, but that the results indicated that the Borderline Personality is far more reflective of her particular personality functioning. He referred to her problems with self-alienation and social-alienation. He stated that the beneficiary has always had trouble in forming relationships: that she has always been a giving person, but that she always gets herself punished. He stated that her lowered abilities are part of the problem, but that the cultural deprevation and lack of opportunity have been the major components of her lack of development of self-assuredness. He stated that the beneficiary, in response to his question to her as to what she got out of her therapy with Dr. Kraft, replied:

"It's finally somebody who listens to me -- somebody who helps me. I'm understanding myself."

Dr. Riddle testified that he was impressed that the beneficiary's visits to the Emergency Room for attention to her anxiety symptoms have been much decreased since she began therapy with Dr. Kraft. He stated that Dr. Kraft has helped her to understand herself and that this has helped her to be an integrated and self-functioning individual.

In regard to Dr. Rodriguez's questioning of the alliance between Dr. Kraft and the beneficiary, Dr. Riddle stated that he could not understand Dr. Rodriguez's concern. He testified:

"The alliance she has with this particular therapist, Dr. Kraft, is one of the most healthy, supporting, and maybe nurturing situations that she's known."

Dr. Riddle stated:

"I just don't think that the data suggests that, you know, vegetative depression is the major problem -- and with medication, it will be O.K.. I just... I don't believe that medication cured anybody, and she indicates her current medication helps her only to sleep. Mrs. [the beneficiary] just needs a lot of support and direction. And with therapy, I think she will gain insight slowly. And I think a number of professionals have commented. I don't see how we can disregard that."

In answer to a question by Mr. Voharis as to why Dr. Riddle does not feel that the beneficiary suffers from vegetative depression, the latter stated:

"The response of the medication. It hasn't cured her emotional state. It has allowed her to sleep."

He stated that the results of her testing show that her depression is situational or exogenous as opposed to endogenous. He referred to the MMPI results and the Rorschach tests as not being at all supportive of a diagnosis of major depressive disorder, and that these test results do suggest a Borderline Personality Disorder.

At this point, Dr. Riddle and Dr. Kraft went into detail in explaining the MMPI results which lead to a diagnosis of Borderline Personality Disorder rather than a major depressive disorder. The significantly high scores are those of subjective depression and mental dullness, and that the psychomotor retardation and physical malfunctioning scales

were within one degree of the normative range. Dr. Riddle stated that the scales on Brooding, Psychomotor Retardation and Physical Malfunctioning would be significantly higher than the normative scale if there were indications of a major depressive disorder, and that in the testing of the beneficiary, there was not an indication of such a disorder. he stated:

"Many of these subscales are just based on just a few items, and so it is very important that you have a fair degree of elevation in order to have, you know, a true sampling of what's going on. And the mental dullness one is at the 95th, and there are, I believe, 12 items influencing that score. That is a little bit of a persuasive argument to me as far as mental dullness and subjective depression and not the vegetative depressions."

Dr. Riddle and Dr. Kraft then explained the sub-scale testing results of the psychopathic-deviate scale (Exhibit 29) -- scale 4 (pd. +4K, page 1 with sub-scales on page 2 pd 1 through pd 4B), which deals with acting out emotions into behaviors. Dr. Riddle reiterated that the overall profile suggests a Borderline Personality Disorder and not a Major Depressive Disorder because there was significant elevation on the psychopathic-deviate scale (about 97). Dr. Riddle explained that the social alienation scale has 13 components and the self-alienation scale has 12 components. He contrasted this to the Authority Conflicts scale which has only 7 components. The social-alienation and self-alienation scales, he stated, were respectable item selections on which to make a statement due to the number of components in arriving at the scale score.

Dr. Riddle characterised the Borderline Personality as one which exhibits:

1. Poor interpersonal relationships
2. Inability to form lasting relationships
3. Impulsiveness -explosive type nature which is usually intermittent
4. Inability to gain from experience -- repetitive, self-defeating behavior
5. Some quality of depression, but the depression is situational they create all of their misfortune.

He stated that the Borderline Personality is complex, but that basically these people are in touch with reality. They do not benefit from life experiences much of the time, and they have a tendency to act out; get themselves alienated, and then they project the blame on

on to the environment. He explained that the treatment of the Borderline Personality is frustrating and that it is difficult to see consistent gain over a period of time.

Dr. Riddle stated that it is difficult to get the Borderline personality to commit to therapy, and that when one does, therapy will take a long time -- several years. He stated:

"They need direction. They need a place in which to deal with these conflicting social experiences, and a not-well-understood personality problem, in order to get some insight, and some direction, and just some support... These people are still very needy, you know, they continue seeking, but they continue to experience an awful lot of alienation."

In response to whether medication is useful in treating a person with a Borderline Personality Disorder with secondary reactive depression, Dr. Riddle stated that if the medication enables them to sleep, then that is important. However, he stated that the medication does not enable these people to deal with their poor judgment and long history of self-alienation and rejection. He stated that they need tremendous amounts of support and direction, and that they require a certain amount of a therapist's interpretation in order to gain insight into what is happening in their lives.

Dr. Kraft stated that Meissner ( see Exhibit 31) breaks down nine different types of Borderline Personalities and the proper treatment of each type. He referred to the Dysthymic Personality as being the type of Personality Disorder from which the beneficiary suffers, and he referred to Meissner's treatment recommendations that target symptoms be treated with neuroleptics and tranquilizers and that psychotherapy be expressive. Dr. Kraft has testified that his treatment of the beneficiary conforms with Meissner.

In response to the general treatment modalities useful in dealing with the Borderline Personality, Dr. Riddle stated that group therapy is not generally useful because the patient requires the individual support and nurturance of a therapist. He stated that these patients must first get to a level where they can deal with the disclosure and alienation of other group members before group therapy could be

utilized. He stated that long term individual therapy is the standard of treatment of the Borderline Personality. Dr. Riddle stated that individual therapy would still be proper even if a group therapy modality were utilized.

At the close of the testimony of Drs. Kraft and Riddle, Mr. Voharis suggested that the results of the psychological testing, the Hollister Article and the letter from the psychiatrist from Walter Reed be forwarded to him, in Colorado, so that Dr. Rodriguez could review this information to determine whether any of it would alter his prior opinion.

On May 7, 1984, Dr. Kraft forwarded a copy of the psychological test results, <sup>and</sup> a copy of the chapter sections of the book referred to in the hearing by Dr. L. Hollister to Mr. Voharis and to the Hearing Officer. On June 29, 1984, Dr. Kraft forwarded a consultation report on the beneficiary from Dr. Wayne Bemis Batzar and Dr. Emmanuel G. Cassimatis of Walter Reed.

The consultation report from Drs. Batzar and Cassimatis states, in part:

"2. Pertinent History: [the beneficiary] has been treated in the Walter Reed Outpatient Psychiatry Clinic since November 1982. Her treatment has consisted of antidepressant medication given as an adjunct to psychotherapy provided privately by Dr. Thomas R. Kraft.

"3. Present Condition: [the beneficiary] currently complains of being mildly depressed. She feels that her medication (norpramin) is helpful; symptoms of depression have worsened when she has stopped the medicine for brief periods. She is also experiencing marital discord. She reports that psychotherapy has been a stabilizing influence for her, and feels that, once frequent physical complaints and emergency room visits have stopped as a result of treatment.

"4. Diagnosis; DSM III Axis I Dysthymic disorder (300.40)  
Axis II Borderline Personality Disorder (301.83)

"5. Recommendations: [the beneficiary] has a chronic

condition (borderline Personality Disorder) with associated depression. She seems to receive continuing benefit from medication, which this clinic provides, as well as from private psychotherapy. Continuation of this treatment is recommended."

#### ISSUES AND FINDING OF FACT

The primary issue in dispute is WHETHER THE OUTPATIENT PSYCHOTHERAPY AFTER MAY 30, 1982, WAS MEDICALLY NECESSARY AND APPROPRIATE CARE.

A secondary issue as to the efficacy of Peer Review will also be addressed.

#### REGULATIONS

Regulation DoD 6010.8-R is promulgated under the authority of, and in accordance with, Chapter 55, Title 10, U.S.C.. It establishes policy for the operation of CHAMPUS and it has the force and effect of the law.

Chapter IV, DoD 6010.8-R, defines basic CHAMPUS program benefits.

A. General - The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. In many of its aspects, the Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

A.1. - Scope of Benefits. Subject to any and all applicable definitions, condition, limitation, 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.

Paragraph G., Chapter IV, DoD 6010.8-R  
Exclusions and Limitation. In addition to any definitions, requirements, condition, and/or limitations enumerated



and described in the 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.

Chapter II, DoD 6010.8-R contains definitions regarding CHAMPUS.

B, 104. Definition of Medically Necessary. "Medically Necessary" means the level of services and supplies (i.e., frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury (including maternity care). Medically necessary includes concept of appropriate medical care.

B, 14. Appropriate Medical Care. means;

a. That medical care where the medical service performed in the treatment of a disease or injury, or in connection with an obstetrical case, are in keeping with the generally acceptable norm for medical practice in the United States;

b. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed and/certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

c. The medical environment in which the medical services are performed is at the level adequate to provide the required medical care.

Section 844, DoD Appropriation Act, 1978, P.L. 95-111 contains restrictions on funds appropriated for CHAMPUS.

"None of the funds contained in this act are available for the... (CHAMPUS) shall be available for ... (9) any service or supply which is not medically or psychologically necessary to diagnose and treat a mental or physical illness, injury, or bodily malfunction as diagnosed by an... (Authorized individual provider)."

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury are a benefit of the CHAMPUS Basic Program subject to all applicable limitations and exclusions. Services which are not medically necessary are specifically excluded. The Regulation defines "medically necessary" in part, as the level of

of services (frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury. "Medically necessary" includes the concept of "appropriate medical care" which the Regulation defines, in part, as the generally accepted norm for medical practice in the United States.

Questions pertaining to medical treatment are referred to medical peer review for expert assessment. The Assistant Secretary of Defense for Health Affairs as stated, in OASD(HA) 06-80, a prior final decision:

"The general medical community has endorsed peer review as the most adequate means of providing information and advice to third party payors on medical matters which may be in question."

This case has been reviewed by three separate peer reviewers on many occasions, and, most recently, in April and August of 1983. In addition, the Medical Director of OCHAMPUS has also reviewed this case on three separate occasions: November 9, 1983, April 19, 1984, and July 26, 1984.

It is undisputed that the beneficiary was ill and was suffering from a significant condition which required outpatient therapy. However, it was the nature and extent of her treatment by Dr. Kraft which was questioned by the Peer Reviewers and Dr. Rodriguez.

The gist of Dr. Kraft's testimony was that the beneficiary was progressing slowly, that her life was being kept organized by virtue of the psychotherapy, that she was a borderline personality whose depression was exogenous and not treatable by anti-depressant, and that her lack of education, cultural deprivation and race contributed to the fact that therapy was so slow in progressing. He presented the evaluation by Dr. Aisenstein, expert testimony by Dr. Riddle, and various psychological testing results and literature to support his contention that psychotherapy sessions with the beneficiary were medically necessary throughout and continue to be medically necessary. He testified that he tried marital therapy and environmental manipulation, and that group therapy was not appropriate for the beneficiary.

In accordance with the agreement of all parties at the Hearing, the

psychological testing results, the Hollister Article and the letter from Drs. Batzar and Cassimatis were submitted to the Medical Director of OCHAMPUS for his evaluation. On August 7, 1984, Dr. Rodriguez issued a "Statement Regarding the [beneficiary's] Hearing by the OCHAMPUS Medical Director, Alex R. Rodriguez, M.D. on July 26, 1984." The basis of Dr. Rodriguez's "Statement" includes: the May 7, 1984 letter of Dr. Thomas Kraft; some psychological tests, interpretations for projective tests including Rorschach, Thematic Apperception Test, MMPI, Bender-Gestalt; a number of photocopies, references, including clinical pharmacology, psychotherapeutic drugs, and some other statements; letters from the provider; letters from Dr. Aisenstein; and the June 19, 1984 letter from Drs. Batzar and Cassimatis.

Dr. Rodriguez, in response to the assertions of Dr. Kraft and Dr. Riddle that the beneficiary's depressions was reactive and non-endogenous and therefore not responsive to medications, stated, in part:

"I...[refer] to a letter from Dr. Cassimatis dated June 19, 1984, which indicates that the beneficiary was on anti-depressant medication since 1982, and while she continues to have mild mood dysphoria or depression, 'she feels that her medication (Norpramin, which is the anti-depressant medication) is helpful. Symptoms of depressions have worsened when she stopped the medicine for brief periods.' In effect, the medication has been specifically prescribed and she has been specifically responsive to that. That is not characteristic of reactive depression... but is more characteristic of a biologically induced or endogenous depression. This woman does, in fact, have response to medication which was clearly demonstrative of an endogenous depression." ("Statement" page 1)

Drs. Kraft and Riddle testified that the fact that the beneficiary was black, educated only through third grade, and culturally deprived caused the therapy to continue for a longer than usual period of time.

In response to this assertion, Dr. Rodriguez stated, in part:

"...there is nothing to substantiate from scientific literature, that such persons who have low educations, may be culturally deprived, or may be from a certain racial or ethnic group, specifically require longer outpatient or inpatient psychotherapy...

"If he is saying that she is intellectually slow, it is difficult for her to comprehend or to benefit from insight-oriented psychotherapy, then I think a serious question should be raised about her eligibility

for therapy in the first place. Intensive insight oriented psychotherapy, would require the capacity to understand the cognitive and intellectual expressions of one's psychological dysfunctions and related dysfunctional attitudes and behaviors or feelings.... So, if he would like to contend that, I would agree that perhaps then, maybe, she was not a candidate in the first place and he should have known that clearly within the first weeks of therapy in 1974."  
("Statement" page 2)

As to Dr. Kraft's testimony that the beneficiary and her husband were reluctant to participate in marital therapy, Dr. Rodriguez stated, in part:

"...there is very limited information that would indicate two things. First, Dr. Kraft's capacity to provide marital therapy, that is to say his credentials and experience and the fact that he was comfortable providing marital therapy for other patients and may have understood the indications and was capable of providing such services, is not known... On the other hand, there is nothing which has been addressed in these initial and other documents which would indicate that the reluctance by the beneficiary and her husband to respond was, in fact, not addressed as a therapeutic issue itself... one of the major reasons she was continuing to dysfunction in her life was because of so-called reactive circumstances of her dysfunctional marriage. The marriage therapy... should have been dealt with in a more prescribed and focused fashion as an element of her individual psychotherapy... So if Dr. Kraft was saying that she was not a candidate and that marriage therapy was not medically or psychologically necessary, he has not provided the basis from which that decision was made. On that basis, I find that simply the fact that it was tried twice and did not work was not a satisfactory justification either for providing or not continuing to press for it in the individual psychotherapy that he provided."  
("Statement" pages 2-3)

Dr. Kraft testified that he was constantly supportive of the beneficiary's efforts to obtain employment by obtaining information and writing letters for her. He also stated that she was still unable to get along with others well enough to sustain employment, but that she should be employable in about one year. On this subject, Dr. Rodriguez stated, in part:

"Dr. Kraft and [the beneficiary] are now affirming that this [encouragement in gaining employment for the beneficiary] was, over a period of several years,

not a major therapeutic goal, then it was a major oversight by Dr. Kraft to not include that in the medical records maintained over time. If... a major vocational environmental manipulation [was] occurring as a therapeutic strategy... it was not documented...

"If this patient on the other hand was seriously depressed, as the record clearly reflects she was for several years, and if in fact, she was not receiving the medication or other services that may have assisted her in breaking through this depression and through her dependent relationship upon Dr. Kraft, it may have been part of the resistance to not engage in marital therapy, and may have been part of the resistance to not go out and find a job or to hold a job. I conclude that this further underscores the need for certain environmental manipulations with concurrent benefits of medication and perhaps marital therapy. Some kinds of therapies outside of the individual intensive psychotherapy, such as medication, were clearly indicated and not provided.

"...There is nothing to clearly indicate that she would be fully employable in a year or would not be fully employable.

"The one thing that I find from the record to substantiate that perhaps she did become more able to be employed is noted by her progress with the beginning of medication in November of 1982.

"It is clear that any substantial turns in her therapy began after [November 1982]; and I believe that there is some indication that perhaps the correlated individual psychotherapy, plus medication, plus some environmental manipulation plus the press of the peer review questioning the care and perhaps intensifying the goal setting by Dr. Kraft very likely caused this beneficiary and the provider to actually have had further gains during the period of 1983 to 1984 than they had had in the previous several years..."  
("Statement" pages 4,5, and 6)

Dr. Kraft and Dr. Riddle testified that group therapy would not benefit the patient until she had a better feeling and sense about herself.

Dr. Rodriguez responded to this position:

"However, if one is speculating that after 6 to 8 years of intensive outpatient psychotherapy, the therapist is still working on the therapeutic alliance and that it is so fragile that it would preclude or contraindicate group therapy, then I find absolutely no evidence in the record that this beneficiary was not a candidate

for group therapy, particularly on that theoretical basis... There is nothing in the clinical records, such as MITRs sent for peer review that established definite professional contraindications for group psychotherapy.

"However, it was clear that this woman was so socially isolated, having so much difficulty with others that I think that very much like borderline patient who are hospitalized and who daily or frequently receive group therapy, that she was in fact a candidate for group therapy very early in the individual psychotherapy.

"...some specific justification for inclusion or non-inclusion [in group psychotherapy] should have been determined during the early phases of therapy. It is not uncommon for complimentary group and individual therapy to be used to potentiate individual insight-oriented psychotherapy, particularly for isolated people who have difficulty in relationships...

"This theoretical response by the provider for non-inclusion in group therapy, like his justification for non-inclusion in marital therapy, is not substantiated by the record. In fact, it is not substantiated by what Dr. Kraft has revealed about the psychopathology experienced by this beneficiary, in both the written and Hearing records."

("statement" pages 5 and 6)

Drs. Kraft and Riddle's testimony that characterologically based psychopathology would not benefit from environmental manipulation was found by Dr. Rodriguez to be without foundation from both medical and psychological scientific literature. Dr. Rodriguez stated, in part:

"...with respect to the specific environmental manipulation, that the record of this patient's personality (characterological construction) and behavior would strongly suggest that it could have been beneficial to this beneficiary at an earlier time in therapy. In general, environmental manipulation is a standard adjunctive course for patients who are generally isolated or who are bogged down in some psychopathological condition that inhibit meaningful social or occupational pursuits. That is the standard upon which community mental health services and is a standard upon which, particularly, the community treatment model has proven to be a very successful model for people who have chronic emotional diseases which are unresponsive or resistant to conventional insight or/and supportive psychotherapy."

("Statement" page 6)

Dr. Kraft testified that the goal for the beneficiary was to resolve the question of whether staying with the husband or independent life would be beneficial. Dr. Rodriguez stated that this goal was absolutely relevant and should have been focused on much earlier in the therapy. He stated that the resolution of the marital relationship should have been a critical part of the therapeutic planning and services in the first year or two of the therapy.

As to the testimony by the beneficiary, Dr. Kraft and Dr. Riddle that the anti-depressant medication merely helped her to sleep and that she was reliant on her therapeutic relationship with Dr. Kraft for help in her daily problems, Dr. Rodriguez stated, in part:

"According to some of [the beneficiary's] comments, her understanding was that the medications were to help her sleep which was a problem, and I would say that the anti-depressant medication would treat one of the so-called 'vegetative symptoms' of depression that she experienced, which was difficulty in sleeping.

"One does not prescribe anti-depressant medication simply to improve sleep. Physicians prescribe sleep medications, soporific medications for people who have simple anxiety-related or sleep cycle-aberrant sleep disorders. For the person that has depression related sleep disorders, anti-depressant medication is the treatment of choice. This beneficiary had more than just a sleep disorder. The medications were being prescribed because of depressed mood, because of vegetative symptoms of depression, problem in terms of her level of energy, in terms of her level of interest in external activities, as well as for sleep, and apparently periodically for disturbances in other kinds of biologically related drives and habits.

"Therefore... it is clear... that she did improve along several aspects of her depression that the medication, therefore, was specifically indicated for her depressive disorder."

("Statement" page 7)

With regard to Dr. Riddle's testimony that the medication did not cure the beneficiary's emotional status, and that the MMPI showed the problem as exogenous and the depression as situational, Dr. Rodriguez stated, in part:

"...her positive response to medication clearly shows that she does have an endogenous depressive disorder and that while it may have been exacerbated by external conditions, a troubled marriage, difficulty obtaining

work, perhaps a feeling of lack of accomplishment in life related to her lack of meaningful pursuits and pleasurable activities, that, in and of itself, there is nothing that an MMPI or other test could provide that would clearly substantiate that this was a totally an exogenous depression and not endogenous. The woman responded to medication. That in itself, is an indication that she had an endogenous depression, she had vegetative symptoms and they were not solely related to external conditions.

"The Rorschach test, by the way, is as non-specific as the MMPI and TAT in terms of specifically defining endogeneity. They can identify areas of perceived environmental stress or experienced internal stressors, but they do not, in and of themselves, specifically exclude or substantiate the endogenous, vegetative, biologically based or mediated depressions. I find it difficult to believe that a Ph.D. psychologist would say, on the basis of those findings and psychological literature on these tests that an endogenous depression would therefore be excluded.

"The fact that she was not 'cured' by her medication means nothing. It is clearly stated by the doctors at Walter Reed that her condition was improved; that was objectively indicated and the fact that she was not totally cured says nothing except that Dr. Riddle knows very little about psycho-pharmacology. Medications rarely cure a psychological condition. If anything, they at best might treat the symptoms or occasionally may treat to some extent the underlying biochemical abnormality. Depression is never cured by medication..." ("Statement" page 8)

Dr. Riddle testified that the beneficiary, as a patient, needed several years to get insight and directional support without which she may have experienced divorce or child problems. Dr. Rodriguez addressed this issue, in part, as follows:

"I would agree that borderline personality disorder can often be a very difficult condition to treat, as well as very difficult for a patient to experience. Such individuals have a very disordered sense of self, a very uneven internal emotional life that is often resulting in problems with adequately testing reality and maintaining meaningful relationships, in employment, etc.

"APA peer reviewers and I have never contended that this beneficiary was not ill and that she was not suffering from significant condition that required outpatient therapy.



"What we have contended is that after several years of therapy, her progress as of 1982-83 remains so uneven and apparently so blocked that it was not going to reasonable be improved by continued indefinite period of therapy with this therapist, who has such indefinite and ambiguous treatment goals.

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"This beneficiary clearly had a depression that was responsive to medication. That depression was not adequately evaluated over a period of several years. Thus, possible gains that she might have had in outpatient psychotherapy with Dr. Kraft or other therapists was minimized by the lack of her having the availability of medication... However, to use as a justification, indefinite, continuing outpatient insight-oriented psychotherapy for this beneficiary is not substantiated solely by her condition. It has to be substantiated by the treatments provided, by the competence of Dr. Kraft to effect change and progress, as well as the ability of [the beneficiary] to respond to the therapy. The therapy services provided by Dr. Kraft before institution of medication in late 1982 were clearly not being effective. Progress had plateaued because of limited treatments. The APA peer reviewers, over a period greater than a year, were showing increasing concern about that and finally decided that benefits should be limited because this beneficiary was no longer showing progress--that is to say that the treatments were not adequate to treat her condition and, therefore, were not medically necessary."

("Statement" page 9)

Dr. Rodriguez did state that for the period of time since the beneficiary has been on medication, that "she has probably been able to gainfully use insight-oriented psychotherapy." He stated that prior to receiving medication, her insight-oriented psychotherapy had little value and "could be reasonable considered not medically necessary." ("Statment" page 10)

As for the use of anti-depressants for the dysphoric personality, Dr. Rodriguez stated, in part:

"... Dr. Kraft and Dr. Riddle do not have credentials, training or experience with medication to be able to establish that patients with dysphoric conditions would not respond to anti-depressant medication... it is clear that his patient, like many, many patients

with major affective disorders, and even some persons with mixed depressive and borderline features such as this beneficiary had, are not only dysphoric, but are responsive to medication. Let the act stand for itself; this beneficiary responded to the medication with reduced dysphoria. That is the core point."  
("Statement" page 10)

Finally, Dr. Rodriguez addressed the psychological testing performed on the beneficiary in 1984 and the statement by Dr. Kraft that prior periodic psychological testing was not routinely done as they are cost prohibited. Dr. Rodriguez stated, in part:

"...this beneficiary was so resistant to treatment, imposing such a therapeutic impasse for a number of years that for a clinical psychologist such as Dr. Kraft, who [has] not performed periodic psychological tests to assess the causes or to have asked for an independent opinion, does raise some questions about his belief in psychological tests and the appropriateness of psychological tests, and his grasp of the therapeutic bind he and the patient were in.

"... most psychiatrists and psychologists as a matter of practice and as a matter of periodicity in evaluations, probably want psychological testing at least every couple of years. In fact, testing provides some kind of therapeutic validation and substantiation and some objective data to mesh with not only mental status exams, other objective data such as clinical laboratory tests, and responses to medications, as well as the subjective input from the patient and other subjective data. All of the subjective and objective data creates a data base from which a therapist can best be able to regularly formulate a composite assessment and develop an ongoing treatment plan. That is just the concern here, that there was a limited data base upon which we have limited assessment, limited documentation of assessment, and limited and ambiguous treatment plan."  
("Statement" page 11)

All of the peer reviewers agreed that outpatient psychotherapy was needed and provided. It was in April of 1982 that the peer reviewers raised questions of the continuing medical necessity for outpatient psychotherapy after May 30, 1982. Basic to the concern of all reviewing physicians was the lack of medication for the beneficiary prior to November 1982, when Norpramin was prescribed for her by a psychiatric resident at Walter Reed. They also expressed concern about the adequacy of the treatment plan, the appropriateness of the therapeutic approach

the apparent lack of progress after seven years of therapy, and the lack of adjunctive programs of support outside of the individual psychotherapy program.

Dr. Rodriguez, in his November 9, 1983, assessment noted that a combination of medication, environmental manipulation and individual therapy were needed by the beneficiary. The beneficiary, Dr. Kraft, the psychiatrists at Walter Reed, and Dr. Rodriguez have all concurred that the medication was helpful to the beneficiary.

Basically, Dr. Kraft, though admitting that the medication was helpful to the beneficiary and that she had made substantial improvement in her insight-oriented psychotherapy since beginning on the medication, maintained that the depression suffered by the beneficiary was exogenous and not amenable to treatment by anti-depressant medication. Dr. Rodriguez, in his July 26, 1984, "Statement", refuted this contention by the facts themselves. Anti-depressant medication was prescribed, it was taken, and it was effective. The "Statement" by Dr. Rodriguez also addresses the inadequacies and ambiguities of Dr. Kraft's treatment plan and goals. He thoroughly discusses the lack of marital therapy and inadequacy of environmental manipulation with regard to this patient, and he explains the role of group therapy in the treatment of the borderline personality.

The psychological testing results, upon which Dr. Kraft relied so heavily in the Hearing, were also addressed by Dr. Rodriguez and demonstrated to be inconclusive on the issue as to whether the depression of the beneficiary would be amenable to treatment by anti-depressant medication. Again, regardless of the test results, the medication was prescribed, taken, and effective.

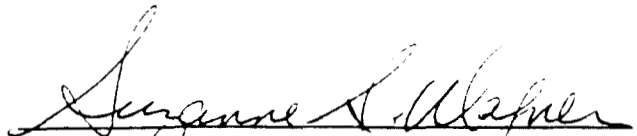
The medical necessity of the individual psychotherapy sessions with Dr. Kraft after May 30, 1982, has not been substantiated in the record. The assertions made by Dr. Kraft have been addressed and refuted by the medical peer reviewers and the Medical Director of OCHAMPUS.

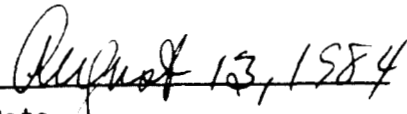
Dr. Rodriguez and the medical peer reviewers agree that the care given the beneficiary by Dr. Kraft was empathetic, caring and attentive. However, they also all agree that the care was not thorough, and Dr. Kraft has not adequately met the burden of substantiating that the care he gave the beneficiary was medically necessary and at the appropriate level. The APA peer reviewers, over a period greater than a year, voiced increasing concern about the slowness of progress and limited treatments, and they finally decided that benefits should be limited because this beneficiary was no longer showing progress. They concluded that the treatments were not adequate to treat her condition, and therefore, were not medically necessary. Dr. Kraft has presented no new evidence which would alter that decision.

The Hearing Officer find that neither the beneficiary nor the provider has presented any new information which would alter the decision of the Peer Reviewers and Medical Director of OCHAMPUS to deny cost-sharing for outpatient psychotherapy after May 30, 1982.

SUMMARY

In summary, it is the Recommended Decision of the Hearing Officer that CHAMPUS Cost-sharing of outpatient psychotherapy after May 30, 1982, should be denied on the basis that the care in question provided after May 30, 1982, by Dr. Kraft has not been documented to be medically necessary and appropriate care due to such limited progress over so long a period of time and the questionable efficacy of the therapy provided.

  
SUZANNE S. WAGNER, HEARING OFFICER

  
Date