ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

FEB 4 1985

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

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) File 84-56
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-56 pursuant to 10 U.S.C. 1071-1092, and DoD 6010.8-R, chapter X. The appealing party is the treating physician, Jose deZayas, M.D. The beneficiary is the son of a deceased enlisted man in the United States Air Force. The appeal involves the denial of cost-sharing of psychiatric care from March 3, 1983, through December 23, 1983, at the Grant Center Hospital, Miami, Florida. The amount in dispute is $1,019.50, which are the charges not paid by the beneficiary's other health insurance.

The hearing file of record, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. Dr. deZayas, the appealing party, waived personal appearance at the hearing and, therefore, there is no tape of oral testimony to be considered. It is the Hearing Officer's recommendation that the entire inpatient psychiatric hospitalization of the beneficiary be denied CHAMPUS cost- sharing. The Hearing Officer found that the beneficiary was not suffering from an acute mental disorder which resulted in his being placed at a significant risk/danger to himself or others at or around the 60th day of hospitalization; the beneficiary did not suffer any medical complications at or on the 60th day of hospitalization; the beneficiary did not require the type, level, and intensity of services that can only be provided in an inpatient hospital setting and that the beneficiary, from date of admission, could have been treated in a partial hospital setting or a residential treatment center.

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

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS cost-sharing of the beneficiary's entire inpatient psychiatric hospitalization and related services. This determination is based on findings that: (1) beneficiary was not suffering from an acute mental disorder which resulted in the beneficiary being of significant danger to himself or others at or around the 60th day of inpatient care, and (2) the beneficiary did not require the type, level, and intensity of services that could only be provided in a hospital setting, and, from the date of his admission, the beneficiary could have been treated in a partial hospital setting or a residential treatment center.

In his Recommended Decision, the OCHAMPUS Hearing Officer correctly stated the issues (although whether the first 60 days of care were medically necessary and the appropriate level of care should have been listed as a primary issue rather than a secondary issue). The Hearing Officer correctly referenced applicable law, regulations, and prior Final Decisions in this area. In particular, the Hearing Officer cited the Department of Defense Appropriation Act of 1983 (Public Law 97-377; 96 Stat. 1830) which prohibited the expenditure of Department of Defense appropriated funds for inpatient psychiatric care during Fiscal Year 1983 in excess of 60 days for new admissions on or after January 1, 1983, except in specific circumstances. Public Law 97-377 has been superceded by Public Law 98-94, for inpatient psychiatric care rendered on or after October 1, 1983. Public Law 98-94 added paragraph (a)(6) to 10 U.S.C. §1079, which paragraph provides:

> "Inpatient mental health services may not (except as provided in subsection (i)) be provided to a patient in excess of 60 days in any year."

It is provided in 10 U.S.C. §1079(i) that:

> "(i) The limitation in subsection (a)(6) does not apply in the case of inpatient mental health services--
>
> "(1) provided under the program of the handicapped under subsection (d);
>
> "(2) provided as residential treatment care;
>
> "(3) provided as partial hospital care; or
>
> "(4) provided pursuant to a waiver authorized by the Secretary of Defense because of extraordinary medical or psychological circumstances that are confirmed by review by a non-Federal health

professional pursuant to regulations prescribed by the Secretary of Defense."

The above-quoted language in 10 U.S.C. §§1079(a)(6) and 1079(i) have not altered the requirements first set forth in the Fiscal Year 1983 Appropriations Act. The limits are now part of the permanent legislation governing the CHAMPUS.

The Hearing Officer also cited and followed two precedential decisions in this area, OASD(HA) Case File 83-54 (March 1, 1984), and OASD(HA) Case File 84-14 (June 5, 1984).

I concur in the Hearing Officer's findings and recommendations. I hereby adopt in full and incorporate by reference the Hearing Officer's Recommended Decision, including the findings and recommendations as the FINAL DECISION in this appeal.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the inpatient psychiatric hospitalization and related professional psychotherapy services at Grant Hospital from March 3, 1983, through December 23, 1983. This decision is based upon findings that: (1) the acute hospitalization was not medically necessary and was above the appropriate level of care; (2) that, had the CHAMPUS requirements for medical necessity and appropriate level of care been satisfied, the criteria for waiver of the Appropriation Act's 60-day limit was not satisfied. This conclusion is based upon findings that the beneficiary was not suffering from an acute mental disorder which resulted in the beneficiary being of significant danger or risk to himself or others at or around the 60th day of hospitalization and that the beneficiary did not require the type, level, and intensity of services that only could be provided in an inpatient hospital setting, but could have been treated in a partial hospital setting or a residential treatment center . As I have found inpatient care from March 3, 1983, was not authorized, I also find that all services, including inpatient individual psychotherapy and group therapy during the inpatient care are excluded from CHAMPUS cost-sharing. Therefore, the request for waiver of the 60-day inpatient limitation, claims for inpatient care from date of admission, and the claims and appeal of the treating physician are all denied. The Director, OCHAMPUS, is directed to take appropriate action under the Federal Claims Collection Act to recoup any erroneous payments. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

Vernon McKenzie
Acting Principal Deputy Assistant Secretary

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

(Name of Beneficiary)

(Name of Sponsor) (Sponsor's SSN:)

This case is before the undersigned Hearing Officer pursuant to the request of the Provider, Grant Center Hospital for hearing on the OCHAMPUS Formal Review Decision dated November 17, 1983. The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) has granted the Provider's request for a hearing. By letter dated March 22, 1984, Dr. J. de Zayas, attending physician at Grant Center Hospital and the person representing the hospital in this case, waived his right to appear at a hearing and requested that the Hearing Officer decide the case on the records submitted.

This is the Recommended Decision of CHAMPUS Hearing Officer, Edward S. Finkelstein, 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 Provider, Grant Center Hospital, 20601 S.W. 157 Avenue, P.O. Box 1159, Quail Heights Branch, Miami, FL 33187. The sponsor, , is the deceased natural father of the beneficiary. Mr. , died when the beneficiary was about one month old. The beneficiary's mother subsequently remarried from whom she is now divorced.

The appeal initially involves the denial of CHAMPUS cost-sharing for an extension beyond 60 days of inpatient psychiatric care in an amount of $1019.50 (there was a commercial third-party payor who was the primary funding source). An initial denial of the extension of inpatient psychiatric care beyond 60 days was made by the OCHAMPUS Benefit and Provider Authorization Branch and was upheld in a Formal Review Determination issued November 17, 1983.

The Hearing file of record has been reviewed. It is the OCHAMPUS Position that the Formal Review Determination, issued November 17, 1983, denying CHAMPUS cost-sharing for the extension beyond 60 days for inpatient psychiatric hospitalization be upheld

on the basis that it was not shown that the beneficiary was suffering from an acute mental disorder or an acute exacerbation of a chronic mental disorder which resulted in the beneficiary's being placed at a significant risk to himself or a danger to others or that he required a type, level and intensity of care that could only be provided in an inpatient setting. Furthermore, OCHAMPUS asserts that based on the recently submitted medical information, the Formal Review decision granting coverage for the first 60 days of care (March 3, 1982 through May 1, 1982) be reversed as the care provided has now been shown to not have been medically necessary or at the appropriate level of care, thus not eligible for cost-sharing. Therefore, CHAMPUS asserts that cost-sharing for the entire period of care must be denied.

FACTUAL BACKGROUND

The beneficiary, , who was a 12-year old male at the time the services in question were rendered, is the son of a deceased serviceman who died when the beneficiary was one month old from a gunshot wound to the head during military duty. It was never determined whether it was an accident or suicide. Upon recommendation of the Discovery Institute, he was admitted to Grant Center Hospital, Miami, Florida (some 300 miles from his home in Tampa) on March 3, 1983 with admitting diagnoses of Dysthymic Disorder (300.40) and Undersocialized Agressive Conduct Disorder (312.00). (Ex. 6, p. 1) This was the third psychiatric hospitalization for the beneficiary who had been in the Florida Mental Health Institute previously in 1979 and 1982 for nine months each. He and his family (his mother and nine year old brother) had been in outpatient therapy at the Discovery Institute, Tampa, Florida, since his discharge from his last hospitalization at the Florida Mental Health Institute in August, 1982. His mother reported that he has always been difficult--but worse in the last two years. He is rebellious and defiant and had begun lying and stealing and has no friends. He appeared to be always angry, defiant of all authority, withdrawn and depressed and very jealous of his younger brother with whom he had become physically agressive to the point that his mother feared for his brother's safety. (Ex. 8, p. 1)

In February, 1983, the beneficiary was charged with breaking and entering a shed and selling the contents. Two weeks after that, he and another youth were caught breaking into lockers at a local high school. It was after these incidents that the Discovery Institute recommended his admission to the Grant Center Hospital for psychiatric treatment.

On March 31, 1983 Dr. de Zayas, the attending physician at Grant Center Hospital, submitted to OCHAMPUS a request together with additional documentation for Waiver of the CHAMPUS statutory

imposed 60-day inpatient psychiatric care per calendar year limitation because he felt that the beneficiary would require 9-12 months of hospitalization. (Ex. 12, p. 1)

The beneficiary was admitted to Grant Center Hospital for treatment of rebellious, defiant behavior, depression and withdrawal and physical aggression. The beneficiary's complaint on admission was "I get in trouble". (Ex. 9, p. 1) On admission to the hospital, which was voluntary, his mother cited a long history of anti-social and acting out behavior which culminated in his being charged with breaking and entering in February, 1983. Problems in school had also existed for many years with his being oppositional and hyperactive. His mother was very concerned with his preoccupation with morbid thoughts. She stated that he relishes any form of violence and is obsessed with the military. (Ex. 11, p. 1) His physicial examination on admission was within normal limits. (Ex. 10)

Upon admission a psychodynamic formulation was done by Dr. Stephen Friedman, Clinical Psychologist, wherein he set forth the beneficiary's treatment plan which would "focus upon the development of new, more appropriate strategies for expressing his feelings of anger and depression. Techniques for coping with his feeling of confusion and disorientation will also be addressed, and the development of an internalized sense of his own self worth will be encouraged, as will the exploration of the underlying causes of his depression." (Ex. 8, p. 2)

Dr. de Zayas' Progress Note of April 11, 1983 reports little progress with the beneficiary's behavior problems. He states, in part:

> "Since admission to the hospital, this patient has demonstrated continued agitated, unresponsive behavior, coupled with episodes of physical aggression towards peers, and confinement in the Acute Care Unit has been periodically necessary to control this patient; in addition, psychotropic PRN medications have also been utilized to manage the patient. A four week psychological and behavioral assessment indicate that this patient is functioning at a severely impaired level with marked symptoms of depression. He has exhibited episodes of bizarre behavior, such as throwing a discarded tampon at peers, making inappropriate noises, and writing violent phrases on the wall in blood when he had a nose bleed. The patient has shown limited insight into the reasons for his behavior, minimizing his involvement in troublesome incidents. Mood has been angry and depressed and

> the patient has been significantly withdrawn. The patient was recently confined in the Acute Care Unit after he attempted to elope from the hospital." (Ex. 12, p. 2)

Relative to the beneficiary's prognosis, Dr. de Zayas also stated "the beneficiary continues to require inpatient treatment to help in dealing with emotions because he is still prone to express his feelings aggressively at this time and could not be discharged to successful functioning outside a hospital environment." (Ex. 12, p. 2)

The beneficiary had a fairly prolonged stay in the Acute Care Unit (ACU) but eventually demonstrated an increased effort and motivation to obtain discharge from the ACU. After his discharge from the ACU he was involved in a conflict with a peer during which he struck the peer resulting in his re-admission to the ACU where he remained through the end of April, 1983. (Ex. 13, p. 3)

Dr. de Zayas' Progress Note of May 6, 1983 (Ex. 12, p. 1) notes that the beneficiary's admitting diagnosis of Dysthymic Disorder was revised to "Schizophrenic Disorder, Paranoid" as a result of clinical observations and evaluations, including psychological testing. Those evaluations indicated that the beneficiary's poor reality testing, paranoid tendencies and poor judgment made him quite vulnerable to potentially dangerous situations; leaving the beneficiary with the feeling that his anger is uncontrollable.

Dr. de Zayas' reported, in part:

> "This patient requires intensive inpatient hospitalization because of his uncontrollable, aggressive behavior, which could not be successfully managed outside of a therapeutic hospital environment without the patient presenting a significant threat to the safety and well-being of others. The patient is expected to require nine to twelve months of hospitalization and the prognosis for a return to the home and community is good, provided the patient complete (sic) treatment." (Ex. 12, p. 1)

Planned therapeutic individual and family therapy sessions were scheduled throughout the beneficiary's hospitalization in order to identify the problems of communication between his mother and younger brother which had prevented the approprate level of nurturance to occur. From the medical record

it is evident that the individual therapy sessions took place as scheduled.

In his individual therapy sessions he frequently expressed his abundant underlying anger in graphic details focusing upon the gruesome details of what he would like to do with those he perceived to be his enemies. (Ex. 13, p. 3) He had feelings of loss and fears of rejection from his mother--often becoming tearful during such discussions. (Ex. 13, p. 4)

The family sessions, however, according to the medical record, did not take place as scheduled--apparently because of the distance between Grant Center Hospital and the family residence. It is noted throughout the record in the Treatment Plan Progress Notes, as follows:

> March 16, 1983. . ."No family sessions had been held." (Ex. 4, p. 6)
>
> April 13, 1983. . . "Only one family session had been held." (Ex. 4, p. 6)
>
> May 25, 1983. . . "He had a family last week, which was followed by a pass, however, there has been no family contact since that time." (Ex. 4, p. 9)
>
> June 9, 1983. . . "Patient's mother is considering his transfer to another hospital which would be nearer to her home." (Ex. 4, p. 11)
>
> July 6, 1983. . . "Mom cancelled the last two family sessions. . . . Mother is still considering the possibility of moving the patient to another facility. She was once again reminded by staff that it would not be to the patient's best interest to move him at this time." (Ex. 27, p. 28)
>
> September 28, 1983. . . "Mother has stated that she will not attend any more family sessions, a progress meeting will be planned. It is felt that mother will soon take the patient out of the hospital." (Ex. 27, p. 33)
>
> October 26, 1983. . . "A progress meeting was scheduled for last week, but mother did not show up. is very upset that mother did not show up for this meeting. . . . No family sessions have been conducted inasmuch as mother feels that it is too expensive for her to make the trip to the hospital. Some sessions have been held via

conference calls (one with the patient present). Mother does understand that there is a continued need for therapy once the patient has been discharged. She requested that the date for the progress meeting be changed to make it more convenient for herself, but then did not attend." (Ex. 27, p. 35)

November 9, 1983. . . " has been experiencing a great deal of difficulty during this portion of the rounding period in that he has not been able to contact his mother. This has made him extremely depressed, and he is often seen as being quite tearful." (Ex. 27, p. 36)

November 23, 1983. . . "Family sessions have not been held recently as his mother has not been able to overcome financial and transportation problems." (Ex. 27, p. 37)

A psychological evaluation performed on the beneficiary by Shelly Payne, Ph.D. in April, 1983, states, in part:

"Test results indicate strong depressive tendencies. experiences a low energy level and is preoccupied with morbid thoughts of decay, disease, suffering, and death. He views himself as useless, unattractive, and undeserving and harbors the fear that there is something seriously and irrevocably wrong with him at his core. Themes of hopelessness are prevalent in his thinking, as believes no matter how hard he may strive his situation will not improve. Indeed, sees life as facing him with a constant challenge to survive, leaving him with little energy left for pleasurable endeavors. While consciously denies that he would harm himself, his test responses point to a suicide risk. It appears that sees dying as a way out of suffering." (Ex. 14, pp. 3,4)

The report further states:

"In working therapeutically with the issue of trust will be paramount. He will need time to learn that there are people who can be counted on. He will need help in checking his distorted views of the world and considering other perceptions. will benefit from learning: new ways to express his angry feelings besides acting out, the

consequences of his misbehavior, as well as the moral differences between right and wrong. Self-esteem issues need to be addressed so that can begin to feel more positively about himself and subsequently feel comfortable about getting his needs met directly. 's age and his neediness for contact, despite his impulse to push people away, lean favorably for his prognosis." (Ex. 14, pp 4,5)

Three reviewers of the American Psychiatric Association reviewed the case under the CHAMPUS routine psychiatric review at the beginning of June, 1983, and found that the care the beneficiary received for the first 60 days was medically necessary and at the appropriate level of care except they felt that therapeutic trials on at least low levels of neuroleptic (antipsychotic) medications were indicated and that therapy without medications was not cost effective. They approved the initial 60-day hospitalization claim from March 3, 1982 through May 1, 1982. (Ex. 18)

After CHAMPUS requested and received additional documentation from Grant Center Hospital to support their request for an extention of the 60-day per calendar year limitation for inpatient psychiatric hospitalzation, CHAMPUS requested another peer review. On June 15, 1982 two reviewers of the American Psychiatric Association reviewed the case file and indicated that they felt that there was no indication for hospitalization in the first place--"no acute illness and there is no evidence in the hospital records to support the diagnosis of Paranoid Schizophrenia or Dysthymic Disorder." (Ex. 19) They felt that the beneficiary was basically an antisocial youth and that a supervised group home would have been adequate care and that the beneficiary was ready for discharge. (Ex. 19)

On the basis of the Peer Review of June 15, 1983, OCHAMPUS, by letter dated July 6, 1983, denied the request for an extension of inpatient psychiatric hospitalization beyond the 60-days finding that "the documentation submitted did not establish that the beneficiary posed an imminent risk to himself or a danger to others and did not establish medical complications which required 24-hour inpatient hospitalization services and active medical treatment for the beneficiary and did not establish that the beneficiary required services of an intensity and nature that are generally recognized as being effectively and safely rendered only in an inpatient hospital setting". (Ex. 20)

By letter dated July 7, 1983 Dr. de Zayas of Grant Center Hospital requested a Formal Review on the denial of the waiver of the 60-day limitation. (Ex. 21) This letter states, in

part:

"This patient is felt to be a young man suffering from an acute exacerbation of a chronic condition. He feels significant anger and depresssion and suffers from an underlying thought disorder, manifested by a long history of rebellious, defiant behavior, withdrawal and depression, with a worsening in overall functioning in the last two years, leading to physical aggression directed at his brother. This exacerbation is felt to be due to the pressures felt by the patient as he enters puberty caused by greater expectations of him by others, in that he is above average in size so looks somewhat older than his stated age. Therefore, he gives the impression that his behavior should be more mature than what he is capable of and others cannot tolerate his agitative behavior, causing him to feel rejected; thus, he acts out his hurt. The patient is felt to be a significant danger at this time because of his recent acts of physical aggression towards his brother. He requires hospital level care because of the recent increase in the intensity of his acting out behaviors, the failure of outpatient therapy leading to the recommendation of longterm treatment at Grant Center by his outpatient therapist, and his thought disorder which, in conjunction with his high level of depression and anger, predisposes him to act in an irresponsible and often self-destructive fashion. Since admission to the hospital, he has demonstrated agitative unresponsive behavior and physical aggression, requiring confinement in the Acute Care Unit. There have also been episodes of bizarre behavior and psychological testing indicated possible suicidal tendencies.

"The patient is under treatment for a Paranoid Schizophrenic Disorder, Dysthymic Disorder and an Undersocialized Aggressive Conduct Disorder. Hospitalization should be of twelve months' duration (365 days) from March 3, 1983 to March 2, 1984 and the prognosis is good for a return to functioning within the home and community, provided the patient receive (sic) adequate treatment.

. . .

"Treatment objectives will focus on assisting the patient to more effectively express feelings of sadness, anxiety, anger and insecurity in an age appropriate manner rather than to act these emotions out in an immature or anti-social manner. Staff will also work with the patient to help him develop more effective strategies for coping with the demands placed upon him so that he will be able to gain a greater sense of confidence and worth through successful accomplishment of tasks. Finally, through family therapy, the family members will develop more effective patterns of interactions in providing the patient with both the support and discipline necessary to his overall development and success in assuming a more adult level of responsibility. The extended treatment period will facilitate the patient's continued development of close trusting relationships with adults and provide him with both the support and guidance he requires to develop more appropriate social skills and internal means of coping with his occasionally overwhelming feelings of sadness and anger. Additionally, this time will allow the patient to develop and test alternative behavioral patterns in dealing with others while he is maintained within the supportive hospital environment. Without sufficient opportunities to develop and test these alternative responses while receiving on-the-spot feedback regarding his interactions, the patient would not be able to successfully integrate these behaviors and would return to old, habitual and unsuccessful patterns. Because of past failures of outpatient therapy, as well as aggressive acting out behavior, it is not felt that the patient has yet successfully integrated newly learned behaviors or had the opportunity to test them to make outpatient therapy a viable alternative at this time. As the patient becomes more adept at coping with frustrations and expressing feelings, additional time with his family will assist him in trying out new coping skills while he can continue to return to the therapeutic hospital environment for ongoing support." (Ex. 21, pp. 1,2)

On September 1, 1983, the OCHAMPUS Medical Director, Alex R. Rodriguez, M.D., after review of the file agreed with the Peer Reviewers that the record did not indicate that the beneficiary required care in a psychiatric hospital beyond the 60 days; he felt the appropriate level of care would be a Residential

Treatment Center (RTC) after 60 days; there was no indication that the beneficiary was a risk to himself or others at the 60th day of hospitalization; and that the beneficiary's diagnosis was not substantiated in the file and the treatment plan did not support the diagnosis. (Ex. 23)

Based on the medical opinions of the American Psychiatric Association peer reviewers and the concurrence of the Medical Director of OCHAMPUS, a Formal Review Decision was issued on November 17, 1983 denying an extension of cost-sharing beyond 60 days for inpatient psychiatric hospitalization. (Ex. 24, pp. 3-7)

By letter dated December 16, 1983 the Provider, Grant Center Hospital, by Dr. de Zayas, requested a Hearing and submitted additional information regarding the beneficiary. That letter stated, in part:

> "As indicated in the psychological evaluation, the patient did appear to be a suicidal risk, since he viewed dying as an escape from suffering, with his poor reality testing, paranoid tendencies, and poor judgment making him very vulnerable to potentially dangerous situations. Early in hospitalization, the patient did have a very negative evaluation of himself and continued to involve himself in agitating and sometimes dangerous situations, i.e., shoving a peer and on another occasion, threatening to spray cologne in peers' eyes. We strongly feel that, outside of a therapeutic hospital setting, with immediate onsight (sic) counselling available, episodes such as these would quickly escalate into situations in which the patient would indeed physically attack someone else, or provoke an attack on himself.
>
> "During the patient's first months of hospitalization, he continued to have difficulty in identifying emotions and he remained unresponsive and provocative, involving himself in aggressive play and making verbally aggressive remarks. He required admission to the Acute Care Unit for hitting a peer and he remained markedly depressed. He continued to have a difficult course of treatment, was often unable to respond to verbal directions, and engaged in frequent acting out behaviors, showing marked hostility. If this patient had been discharged to a less restrictive setting at this point when he was no longer in imminent danger of harming himself or those around

him, he would not had the time to internalize those behavioral changes which he had only begun to make.

"Treatment was directed at forming trusting therapeutic relationships with this patient, so that he would be able to respond to cognitive, insight-oriented, dynamic therapy, aimed at treating the etiology of his illness, rather than the symptoms. Had the underlyng causes for this patient's depression and physically aggressive acting out not been treated, he would have quickly regressed to his previous levels of depression and aggression, only to again require inpatient hospitalization. Even up through the 60th day of treatment, this patient continued to be very angry, with abundant hostility and was involved in an incident wherein he hit the wall. He remained unable to identify his feelings, however, as he became more trusting of his therapists, he increased his participation in therapy and became more involved in therapeutic tasks designed to help him discover the significance of relating to others, so that he would become more trusting. Thus, he was more willing to explore alternative ways for solving difficulties, rather than to view aggression toward himself or others as the only means of expressing his emotions.

"By the 90th day of hospitalization, the patient's behavior and attitude had improved somewhat and he appeared more intact, however, he continued to have periods of depression and thinking remained confused, disorganized, and referential with bizarre verbalizations and he appeared obsessed with violent thoughts and ideas. The patient's investment in individual therapy appeared fairly positive and the primary area addressed regarded relationships and interactions, since the patient tended to act out his anxiety and anger within his relationships, thus distancing his peers.

. . .

"As the patient became more trusting and more invested in therapy, he improved his ability to maintain appropriate controls and although he continued to require confinement in the Acute Care Unit for aggressive behavior, unresponsiveness, and disruptive acting out, the frequency and severity of these episodes diminished considerably and he

was more able to accept the consequences for his inappropriate behaviors. . . .

"While the patient's behavior continues to present a possible threat to his safety and he has not yet fully addressed his pervasive depression, plans for discharge are being formulated with the family. Due to the financial difficulties felt by the patient's mother, she and her other son are attending therapy near their home and the plan is for the patient to attend sessions while on therapeutic pass, prior to his discharge. It is anticipated that discharge will be appropriate when the progress recently noted has been stabilized. The patient would then be appropriate for oupatient therapy in 30-60 days.

. . .

"This patient has made significant progress in his ability to trust others and willingly share with them his thoughts and feelings. He is able to process the events around him in an objective manner with a good degree of success while still dealing with his ongoing reactions to these events. Thoughts are now more goal-oriented and less obsessed with thoughts of death and destruction. It is felt that this patient has benefitted well from his inpatient hospitalization and these gains could not have been accomplished in less than a complex, multi-disciplinary therapeutic hospital setting. Had this patient been discharged earlier in treatment, he would have been at significant risk to regress to previous levels of destructive acting out behavior and his potential for suicide would have been significant.. . ." (Ex. 25)

By letter dated March 22, 1984, Dr. J. de Zayas, attending physician at Grant Center Hospital, waived his right to appear at the hearing and requested that the Hearing Officer decide the case on the records submitted. He also sent additional documentation including the discharge summary, treatment plan and medical psychotherapy summaries. He further explained that when the beneficiary was admitted to Grant Center Hospital, a commercial third-party payor was the primary funding source and was financially responsible for almost the entire amount of charges of the beneficiary's inpatient hospitalization, therefore, leaving only a balance remaining to be cost-shared by CHAMPUS of approximately $1,000-$2,000. Additional documentation has been received from Grant Center Hospital verifying that the exact

balance is $1019.50. (Ex. 33)

Pursuant to receipt of the additional material contained in Exhibits 25 and 27, a further medical opinion was requested from Dr. Alex R. Rodriguez and on April 11, 1984, the medical opinion was issued. (Exhibit 28). In this opinion, Dr. Rodriguez, responding to the question as to whether the additional documentation (Exhibits 25 and 27) indicated whether the patient at or around the 60th day of hospitalization was suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which resulted in his being put at a significant risk to himself or becoming a danger to himself or others, stated, in part:

> "The issues I had concerns about were in regards to the symptomatology expressed by this beneficiary prior to his hospitalization at Grant Center Hospital. This beneficiary had two previous hospitalizations of nine months each during a period of three years prior to this hospitalization, at the Florida Mental Health Center in Tampa, Florida. We have very little information from those hospitalizations, only some limited information by reference made by Dr. de Zayas in his summary. It does appear that this beneficiary has had a several year history of problems in relationships with significant family members, difficulty with friends, academic problems and behavioral problems in school (this has, more recently, prior to admission, manifested itself in some significant anti-social behavior he had reported to Dr. de Zayas) and a previous history of hallucinations--although again that is not adequately spelled out to substantiate whether in fact that would purely characterize a diagnosis of paranoid schizophrenia. In fact this beneficiary may have required some longer term care placement but the question was did he require placement (1) In a acute care psychiatric facility and (2) some several hundred miles (300 miles) from his home. That was my original question: why was he sent to Miami when there are at least a half a dozen quite adequate CHAMPUS approved acute care facilities and, in addition, partial psychiatric hospital programs in the Tampa Bay area. The question not answered and not addressed in any way in this chart is why he was removed from his family. There are some incidental notations made in the record in regards to the mother believing she can no longer control this beneficiary's behavior and her concern

about his anti-social behavior and aggressiveness and hostility, but again no mention is made why the decision was made for transfer. My other concern is that her removal from the treatment on an ongoing basis became a complication in the therapy and that is clearly documented at several points in Dr. de Zayas psychotherapy notes. He notes on September 28, 1983 that the patient's mother expressed concern about her inability to control him and the issue of a possible transfer to a more local hospital in the Tampa Bay area was once again brought up. This may be in part responsible for his behavioral regression during this period. In fact, the beneficiary's removal from his home and from his family was likely thwarting any kind of successful approaches that the treatment program may have been trying to implement. . . . Nevertheless, it is also noted in the record at least on a couple of occasions that the beneficiary's mother was not able to make the trips to Miami and therefore missed meetings, which were infrequent enough. Therefore, I also question this placement some several hundred miles removed from the home of record where family involvement was an absolutely critical and absolutely medically necessary requirement. I find nothing in this record, then, that would justify care beyond 60 days. Furthermore, I strongly question whether an initial admission was medically indicated, in accordance with peer reviewers comments that question the indication for hospitalization. The appropriate level of care - on or about the time that he was hospitalized at Grant Center - was a partial hospital level of care at least, or a RTC (residential treatment center) level of care at most, relative to the intensity and comprehensiveness of services medically indicated.. . . There is an RTC in Miami, Florida, but again I think our experience would tell us, as his psychological problems clearly manifested themselves before and after the admission at Grant Center, that this beneficiary required the active involvement of his family in any psychotherapeutic placement. Therefore, I find that, only if there was absolutely no availability for partial hospitalizaton in the Tampa Bay area . . . then an RTC placement would have been the appropriate level of care. . . . Therefore, I find that none of the care during this period can be justified as medically necessary even though it may have been

compassionate, caring, and professional." (Ex. 28, pp. 1-3)

The Hearing Officer, Edward S. Finkelstein, based on the record in this case, is submitting his Recommended Decision.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are:

1. DOES THE MEDICAL DOCUMENTATION SUBMITTED IN THIS CASE INDICATE THAT THIS BENEFICIARY, AT OR AROUND THE 60TH DAY OF HOSPITALIZATON, SUFFERED FROM AN ACUTE MENTAL DISORDER OR ACUTE EXACERBATION OF A CHRONIC MENTAL DISORDER WHICH RESULTED IN HIS BEING A SIGNIFICANT DANGER TO HIMSELF OR OTHERS?

2. DO THE MEDICAL RECORDS SUFFICIENTLY INDICATE THAT THE BENEFICIARY, AFTER THE INITIAL 60 DAYS OF HOSPITALIZATION, REQUIRED A TYPE, LEVEL AND INTENSITY OF SERVICE THAT COULD ONLY BE PROVIDED IN AN INPATIENT HOSPITAL SETTING?

Inpatient Psychiatric Limitations

On December 21, 1982, the Department of Defense Appropriation Act of 1983 (Public Law 97-377, 96 Stat. 1830) was enacted. Section 785 of Public Law 97-377 provided as follows:

> "Sec. 785. None of the funds appropriated by this Act shall be available to pay claims for inpatient mental health services provided under the Civilian Health and Medical Program of the Uniformed Services in excess of sixty days per patient per year. Provided, that the foregoing limitation shall not apply to inpatient mental health services (a) provided under the Program for the Handicapped; (b) provided as residential treatment care; (c) provided as partial hospital care; (d) provided to individual patients admitted prior to January 1, 1983 for so long as they remain continuously in inpatient status for medically or psychologically necessary reasons; or (e) provided pursuant to a waiver for medical or psychological necessities, granted in accordance with the findings of current peer review, as prescribed in guidelines established and promulgated by the Director, Office of Civilian Health and Medical Program of the Uniformed Services."

The clear language of this provision is to prohibit the expenditure of Department of Defense appropriated funds for inpatient psychiatric care in excess of 60 days for new admissions on or after January 1, 1983, except in four specific circumstances. Three of the specific circumstances for which an exception exists (i.e., care provided under the Program for the Handicapped, partial hospital care, and residential treatment center care) are not relevant to this appeal. The fourth specific circumstance established by subsection (e) of Section 785 allows an extension of CHAMPUS cost-sharing for inpatient mental health services beyond 60 days for medical or psychological necessity determined in accordance with guidelines issued by the Director, OCHAMPUS.

In drafting the required guidelines, the language of Senate Report No. 97-580 concerning Public Law 97-377 was considered. The Committee on Appropriations noted that the Act's 60-day limit is the same as the Blue Cross/Blue Shield High Option insurance Plan for federal employees after which CHAMPUS was originally patterned. In further comment, the Committee stated:

> "The Committee recommends bill language limiting the length of inpatient psychiatric care to 60 days annually, except when the Director of CHAMPUS or a designee waives the limit due to extraordinary circumstances." (Emphasis added) Senate Report 97-580, page 30.

Prior to enactment of Public Law 97-377, CHAMPUS limited cost-sharing of inpatient mental health services only under concepts of medical neces.ity and appropriate level of care:

DoD 6010.8-R, Chapter II.B.104. 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 the concept of appropriate medical care.

DoD 6010.8-R, Chapter II.B.14. Appropriate Medical Care. "Appropriate Medical Care" means:

> a. That medical care where the medical services performed in the treatment of a disease or injury, or in connection with an obstetrical case, are in keeping with the generally acceptable norm for medical practice in the United States;
>
> b. The authorized individual professional provider rendering the medical care is qualified to perform

such medical services by reason of his or her training and education and is licensed and/or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

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

The intent of the funding limitation in Public Law 97-377 was clearly to impose additional restrictions on CHAMPUS coverage. Therefore, the CHAMPUS implementing guidelines were based on the Senate Report language of "extraordinary circumstances" for interpretation of the phrase "medical or psychological necessities" of which Public Law 97-377 conditioned the granting of a waiver of the 60-day coverage limitation. As a result, the Director, OCHAMPUS, issued the following interim guidelines on December 29, 1982, for waiver of the 60-day inpatient limitation:

"a. The Director, OCHAMPUS, will grant coverage in excess of 60-days of inpatient mental health services in a calendar year, only if the Director finds that:

"1. The patient is suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which results in the patient being a significant danger to self or others; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient hospital setting; or

"2. The patient has medical complications; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient hospital setting." (See CHAMPUS Policy Manual, Chapter 1, Section 11, page 11.1., December 29, 1982.)

As set forth in these guidelines, the concepts of "extraordinary circumstances" and "medical or psychological necessities" have been interpreted and equated by the Director, OCHAMPUS, as requiring an acute mental disorder presenting a significant danger to the patient or others and, in addition, the condition must require the type, level, and intensity of services that can only be provided in an inpatient hospital setting. (Final Decision OASD(HA), File 83-54)

In March, 1983, OCHAMPUS revised the guidelines to the following:

> "a. The Director, OCHAMPUS, taking into account the findings of professional review, will grant coverage in excess of 60 days of inpatient mental health services in a calendar year if the Director finds that:
>
> "1. The patient is suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which results in the patient being put at significant risk to self or becoming a danger to others; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting; or
>
> "2. The patient has medical complications; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting."

The revision from "the patient being a significant danger to self or others" to "the patient put at significant risk to self or becoming a danger to others" is deemed to be minor wordsmithing and does not change the overall concept. For purposes of applicaton, the two versions are considered essentially equal in their requirements. (Final Decision OASD(HA), Files 84-14 and 83-54)

DoD 6010.8-R, Chapter IV.G. Exclusions and Limitations. In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other Chapters of this Regulation, the following are specifically excluded from CHAMPUS Basic Program:

> 1. Not Medically Necessary. Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury.
>
> 3. Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.
>
> DoD 6010.8-R, Chapter IV.B. Institutional Benefits.
>
> 1. General. Benefits may be extended for those covered services and supplies described in this

Section B of this CHAPTER IV, provided by a hospital or other authorized institutional provider (as set forth in CHAPTER VI of this Regulation, "Authorized Providers"), when such services and supplies are ordered, directed and/or prescribed by a physician and provided in accordance with good medical practice and established standards of quality. Such benefits are subject to any and all applicable definitions, conditions, limitations, exceptions and/or exclusions as may be otherwise set forth in this or other CHAPTERS of this Regulation.

g. Inpatient: Appropriate Level Required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment. If an appropriate lower level care facility would be adequate but is not available in the general locality, benefits may be continued in the higher level care facility but CHAMPUS institutional benefit payments shall be limited to the reasonable cost that would have been incurred in the appropriate lower level care facility, as determined by the Director, OCHAMPUS (or a designee). If it is determined that the institutional care can reasonably be provided in the home setting, no CHAMPUS institutional benefits are payable.

In the present appeal, three reviewers of the American Psychiatric Association who reviewed the case initially under the CHAMPUS routine psychiatric review found that the care the beneficiary received for the first 60 days of inpatient psychiatric hospital care was medically necessary and at the appropriate level of care in accordance with DoD 6010.8-R, Chapter II.B.14., Chapter II.B.104, Chapter IV.G.1., and Chapter IV.G.3. However, the Peer Reviewers did question the efficacy of the overall treatment for the beneficiary--they felt that therapeutic trials on at least low levels of neuroleptic (antipsychotic) medications was indicated and therapy without medications was not cost effective. (Ex. 18) There is a note in the progress note of April 11, 1983 that "psychotropic PRN medications have also been utilized to manage the patient." (Ex. 12) However, that is the only reference to any type of medication being given to the beneficiary during his inpatient hospitalization. All other notes indicate that the mother was against her son taking medication. It is noted in the Treatment Plan Progress Report of May 11, 1983, "At staffing last Friday the issue of medications

was discussed. A major affective disorder seems to be indicated due to family history. According to Dr. de Zayas, continues to have visual and auditory hallucinations, yet mother is resistant to medication. . ." (Ex. 4, p. 9) And again in a Treatment Plan Progress Report dated July 6, 1983 it is noted that "Mother is still resistent to the idea of her son taking medication. When the subject is approached, she becomes upset and tearful." (Ex. 27, p. 27) And in the Discharge Summary it is noted:

> "Even though we were not able to use antipsychotic medications because of the refusal of his mother, it seemed that the thought disorder was less severe in many respects towards the end of his hospitalization. acknowledged not having had any auditory hallucinations for several months prior to his discharge." (Emphasis added) (Ex. 27, p. 25)

Therefore, it is not clear from the record whether or not the beneficiary ever had any type of medication nor was there ever noted a clear reason why his mother was against their use.

The APA reviewers and the Medical Director, OCHAMPUS, concur that inpatient psychiatric hospitalization beyond the 60th day was not warranted as the beneficiary was not suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which resulted in his being put at a significant risk/danger to himself or others at or around the 60th day of hospitalization.

It is clearly evident from the record that the beneficiary has had emotional and anti-social problems in the past (having had two prior hospitalizations at the Florida Mental Health Institute); however, the record does not support the contention of the Provider that the beneficiary posed a significant danger/risk to himself or others at or about the 60th day of hospitalization. In a psychological evaluation performed on the beneficiary in April, 1983, Dr. Payne states "While consciously denies that he would harm himself, his test responses point to a suicide risk. It appears that sees dying as a way out of suffering." (Ex. 14) The Provider apparently was never concerned about the beneficiary being a "suicide risk" during his hospitalization as there is no evidence in the hospital records to support any treatment for the beneficiary for suicidal tendencies. The hospital records support treatment for his behavior problems and for building trust and self-esteem. Based on the peer review of June 15, 1983, the opinion of Dr. Rodriguez and the medical record, I find no evidence that the beneficiary was put at a significant risk/danger to himself or others at or

around the 60th day of hospitalization.

Dr. de Zayas by letter dated December 16, 1983 in submitting additional documentation to support an extension of benefits beyond 60 days, stated:

> "As indicated in the psychological evaluation, the patient did appear to be a suicidal risk, since he viewed dying as an escape from suffering, with his poor realty testing, paranoid tendencies, and poor judgment making him very vulnerable to potentially dangerous situations. Early in hospitalization, the patient did have a very negative evaluation of himself and continued to involve himself in agitating and sometimes dangerous situations, i.e., shoving a peer and on another occasion, threatening to spray cologne in peers' eyes. We strongly feel that outside of a therapeutic hospital setting, with immediate onsight counselling available, episodes such as these would quickly escalate into situations in which the patient would indeed physically attack someone else, or provoke an attack on himself. . . .
>
> "Even up to the 60th day of treatment, this patient continued to be very angry, with abundant hostility and was involved in an incident where he hit the wall." (Ex. 25)

If the beneficiary had been at a significant risk/danger to himself or others at or around the 60th day of hospitalization, the hospital records should document that fact or at least indicate appropriate treatment therefor. There was no such documentation in the record and the closest documentation of significant risk/danger at or around the 60th day was a Treatment Plan Progress Record dated May 11, 1983 (which is at about the 68th day of hospitalization) where it is noted, in part:

> ". is better able to handle his sadness and is less hostile. During individual therapy sessions tear (sic) and sadness are emerging. His thinking is less bizarre and he is better able to handle stressful situations. . . . Staff has noted a decrease in his hostility, as well as his agitation of peers. . . . continues to have visual and auditory hallucinations. . . . Anger and isolation continue to be present, often to the point of tears. His depression appears to have lessened and he is trying hard to accomplish his

goals. . . . " (Ex. 4, p. 9)

At the 68th day of hospitalization, the beneficiary was not indicating any significant risk or danger to himself or others--at least not documented in the normal course of treatment.

The APA peer reviewers (Ex. 19) noted that they felt there was no indication for hospitalization in the first place--"no acute illness and there is no evidence in the hospital records to support the diagnosis of Paranoid Schizophrenia or Dysthymic Disorder" and therefore there was not sufficient documentation to support that the patient was a significant risk/danger to himself or others to warrant a waiver of the 60 day limitation on inpatient psychiatric hospitalization.

OASD(HA), File 83-54 is a precedential Final Decision addressing the degree of risk required to meet the significant risk/danger guidelines for granting a waiver of the 60 day limit. In that case, the Hearing Officer adopted a standard of suicidal or homicidal behavior of a floridly psychotic beneficiary, which standard was concurred in by the Assistant Secretary of Defense (Health Affairs). The decision states that a significant risk/danger could also be posed by less than suicidal or homicidal behavor. The Final Decision, on page 9, states:

> "A more general standard, applied on a case by case review, would be a current risk of serious harm to self or others that requires inpatient hospital care. It is, of course, incumbent upon the appealing party to demonstrate the patient represented such risk that could not be treated in other than an acute level."

In the present case, the Peer Reviewers and the OCHAMPUS Medical Director concurred that the potential risks presented by the beneficiary could have been adequately addressed in partial hospitalization or Residential Treatment Center care. The Medical Director, OCHAMPUS, concluded that the record did not support the contention of the Provider that on or about the 60th day, the beneficiary was placed at significant risk/danger to self or others which could not be treated in other than an acute level. The Hearing Officer concurs in this finding. There is no evidence of any real suicidal or homicidal threat on or around the 60th day of care. The attending physician uses examples of agitated, unresponsive behavior, coupled with episodes of physical aggression towards peers, marked symptoms of depression and episodes of bizarre behavior, "such as throwing a discarded tampon at peers, making inappropriate noises, and writing violent phrases on the wall in blood when he had a nose bleed." These behaviors are not considered by the peer reviewers to constitute a

risk/danger situation. They felt that the beneficiary was basically an antisocial youth and that a supervised group home would have been adequate care.

The Hearing Officer finds that the record in this appeal does not document that the beneficiary was a significant danger or risk to himself or others at or around the 60th day of inpatient care and, at that time did not require the type, level or intensity of an inpatient setting, therefore, the record does not document that the criteria for waiver of the 60 day inpatient psychiatric limitation have been met and CHAMPUS coverage of the beneficiary's inpatient care beyond 60 days in calendar year 1983 should not be authorized.

APPROPRIATE LEVEL OF CARE

Under the Department of Defense Regulation 6010.8-R, Chapter IV, B.1.g. (quoted on pages 18 and 19 hereof), CHAMPUS benefits may be extended for institutional care only at the appropriate level required to provide the medically necessary treatment.

Medically necessary is defined in DoD 6010.8-R, Chapter II,B.104 (quoted on page 16 hereof).

In the context of inpatient mental health care, the CHAMPUS guidelines for granting a waiver of the 60 day per calendar year limitation based on "medical or psychological necessities" require a finding that the patient has an acute mental disorder or medical complication and that:

> ". . . the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting."

It was the opinion of the peer reviewers and the Medical Director that the beneficiary did not require inpatient hospital care but did require partial hospitalization or residential treatment center care. (Ex. 19, 28)

Dr. Rodriguez, in reviewing the file on April 11, 1984, questioned the placing of the beneficiary in an acute facility hundreds of miles from his family. (Ex. 28) It is evident from the medical record in the Treatment Plan Progress Notes that the mother's absences from therapeutic sessions impeded the forming of the therapeutic alliance as family involvement was critical. He stated that "In fact, the beneficiary's removal from his home and from his family was likely thwarting any kind of successful approaches that the treatment program may have been trying to

implement."

In a letter to OCHAMPUS dated July 7, 1983 (Ex. 21), Dr. de Zayas of Grant Center Hospital, stated:

> ". . . The patient is felt to be a significant danger at this time because of his recent acts of physical aggression towards his brother. He requires hospital level care because of the recent increase in the intensity of his acting out behaviors, the failure of outpatient therapy leading to the recommendation of longterm treatment at Grant Center by his outpatient therapist, and his thought disorder which, in conjunction with his high level of depression and anger, predisposes him to act in an irresponsible and often self-destructive fashion."

Dr. de Zayas again commented on the need for inpatient hospitalization for the beneficiary in a letter dated December 16, 1983 to OCHAMPUS, stating:

> "It is felt that this patient has benefitted well from his inpatient hospitalization and these gains could not have been accomplished in less than a complex, multi-disciplinary therapeutic hospital setting. Had this patient been discharged earlier in treatment, he would have been at significant risk to regress to previous levels of destructive acting out behavior and his potential for suicide would have been significant. . . ." (Ex. 25)

In his April, 1984 Medical Opinion, Dr. Rodriguez commented:

> "I find nothing in this record, then, that would justify care beyond 60 days. Furthermore, I strongly question whether an initial admission was medically indicated, in accordance with peer reviewers comments that question the indication for hospitalization. The appropriate level of care--on or about the time that he was hospitalized at Grant Center--was a partial hospital level of care at least, or a RTC (residential treatment center) level of care at most, relative to the intensity and comprehensiveness of services medically indicated. Therefore, I would find this beneficiary, who was not functioning in the school environment, who had run afoul of the law, who was having some significant difficulties functioning at

home due to his aggressiveness and some escalating emotional problems should have more adequately have been removed from the home under social services, placed in a group home or foster home for some period of time to provide him medical supervision and that he should have been treated most likely in a partial hospital program. In lieu of that, since I'm not aware of any CHAMPUS-approved RTC programs in the Tampa Bay area, it would have been only secondarily appropriate to transfer him to a longer term care facility such as an RTC elsewhere in the state of Florida. There is an RTC in Miami, Florida, but again I think our experience would tell us, as his psychological problems clearly manifested themselves before and after the admission at Grant Center, that this beneficiary required the active involvement of his family in any psychotherapeutic placement. Therefore, I find that, only if there was absolutely no availability for partial hospitalization in the Tampa Bay area (which I do not think is the case), then an RTC placement would have been the appropriate level of care. . . . " (Ex. 28, p. 3)

The Hearing Officer also concurs in this opinion of Dr. Rodriguez and finds that inpatient hosptial care received by the beneficiary after the 60th day of hospitalization during calendar year 1983 was above the appropriate level of care. The beneficiary, after the 60th day of care, did not require the type, level, and intensity of services that could only be provided in an inpatient setting. A partial hospitalization in the Tampa Bay area (where his family could be actively involved in his therapeutic treatment) would have been adequate to provide sufficient intensity and comprehensiveness of professional services to meet the beneficiary's treatment needs (See quote from Dr. Rodriguez, above).

CHAMPUS regulation DoD 6010.8-R, Chapter IV,G.3., specifically excludes "services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care."

Due to the finding that the beneficiary's inpatient hospitalzation beyond 60 days in calendar year 1983 exceeded the CHAMPUS limitation and cost-sharing for care beyond the 60th day is not authorized, all services and supplies related to the noncovered treatment are excluded from CHAMPUS coverage.

SECONDARY ISSUES

1. ON OR ABOUT THE 60TH DAY OF CARE, DID THE BENEFICIARY HAVE MEDICAL COMPLICATIONS REQUIRING INPATIENT HOSPITALIZATION?

The peer review psychiatrists and the Medical Director, OCHAMPUS, found that there were no medical complications which would have required that the beneficiary remain an inpatient beyond the initial 60 days of care. The medical record and additional documentation submitted are also devoid of any evidence to support extended inpatient care beyond 60 days due to medical complications.

The Hearing Officer finds that there were no medical complications at or around the 60th day of hospitalization which would require extended care beyond 60 days.

2. WHETHER THE MEDICAL DOCUMENTATION INDICATES THAT THE CARE PROVIDED FROM MARCH 3, 1983 THROUGH MAY 1, 1983 (THE FIRST 60 DAYS OF CARE) WAS MEDICALLY NECESSARY AND AT THE APPROPRITATE LEVEL OF CARE?

Medically necessary services and supplies required in the diagnosis or treatment of disease, injury or illness may be cost-shared under the CHAMPUS Basic Program subject to all applicable exclusions and limitation, pursuant to DoD 6010.8-R, Chapter IV, A.1.:

> "Scope of benefits." Subject to any and all applicable definitions, conditions, limitations, and/or exclusions specified or enumerated in this regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional providers as well as professional ambulance service, prescription drugs, authorized medical and rental of durable equipment."

Medical Necessity and Appropriate Medical Care are defined in DoD 6010.8-R, Chapter II.B.104 resepctively (as set forth on page 16 hereof), as the medical environment in which the medical services performed are at the level adequate to provide the required medical care. Treatment that is not medically necessary is excluded from the CHAMPUS Basic Program pursuant to

DoD 6010.8-R, Chapter IV.G.1. and G.3. (as quoted on pages 18 and 19 hereof).

Both the APA peer reviewers and Dr. Rodriguez questioned whether the initial admission to Grant Center Hospital was medically indicated. The peer reviewers and Dr. Rodriguez both felt that the appropriate level of care at the time of the beneficiary's admission to Grant Center Hospital was a partial hospital level of care. (See quote from Dr. Rodriguez, p. 24 hereof). In Dr. Rodriguez' Medical Opinion (Ex. 28), he further stated:

> ". . . That is concordant with the view expressed by the American Psychiatric Association peer reviewer in reviewing this case that the RTC or partial level of care would have been more appropriate than the initial admission or the acute hospitalization. Therefore, I find that none of the care during this period can be justified as medically necessary even though it may have been compassionate, caring, and professional." (Emphasis added) (Ex. 28, p. 3)

Dr. Rodriguez felt that the first 60 days of inpatient care were not medically necessary as he did in stating that the level of care was inappropriate for care after the 60th day; i.e., the lack of family involvement impeded the patient's care and that a group/foster home, partial hospitalzation or RTC center care was the appropriate level of care.

Although the challenging of the first 60 days of care is a change in the OCHAMPUS position from the Formal Review decision, it comes about as a result of new documentation supplied by the Provider when it requested a Hearing (Ex. 25 and 27).

The Hearing Officer therefore finds that there is sufficient evidence in the record indicating that at no time during the beneficiary's period of care was the acute hospitalization the appropriate level of care. Therefore, cost-sharing for the first 60 days of inpatient psychiatric hospitalization must be denied and recoupment of any payments made by CHAMPUS for the first 60 days must be sought.

SUMMARY

In summary, it is the Recommended Decision of the Hearing Officer that the first 60 days of inpatient hospitalization as well as the inpatient psychiatric care beyond the 60 days should not be cost-shared because the inpatient hospitalization was not medically necessary or at the appropriate

level of care and the beneficiary did not meet the requirements for waiver of the 60 day calendar year limitation. The recommendation is based on the findings that:

1. The beneficiary was not suffering from an acute mental disorder which resulted in his being placed at a significant risk/danger to himself or others at the time of his initial admission.

2. The beneficiary was not suffering from an acute mental disorder which resulted in his being placed at a significant risk/danger to himself or others at or around the 60th day of hospitalization.

3. The beneficiary was not suffering from any medical complications at or around the 60th day of hospitalization.

4. The beneficiary did not require the type, level and intensity of services that could only be provided in an inpatient hospital setting, but could have been treated in a partial hospital setting or an RTC from the date of initial admission.

The Hearing Officer also recommends that the Formal Review Decision granting coverage for the first 60 days of care (March 3 through May 1, 1983) be reversed. Therefore, the Hearing Officer recommends that CHAMPUS cost-sharing for the entire inpatient psychiatric hospitalization of the beneficiary be denied and the file should be returned to the Director, OCHAMPUS, for appropriate action under the Federal Claims Collection Act governing any erroneous payment made for care from March 3 through May 1, 1983.

Edward S. Finkelstein
Hearing Officer

Dated: July 31, 1984