DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

AURORA, COLORADO 80045

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

UNITED STATES DEPARTMENT OF DEFENSE

DEC 04 1985

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) FILE 85-18
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 85-18, pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the beneficiary, as represented by his father and retained counsel, Mark Nacol and Michael Wortham, Attorneys at Law.

This appeal involves the denial of CHAMPUS cost-sharing for daily charges of an administrative psychiatrist, individual psychotherapy by a clinical psychologist and by a physician, and daily drugs and treatment charges provided during inpatient psychiatric hospitalization from July 12, 1982, through February 4, 1984. The amount in dispute involves approximately $45,000 in billed charges.

The hearing file of record, the tapes of oral testimony presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's Recommended Decision that the OCHAMPUS Formal Review Decision be reversed and that CHAMPUS cost-share the services/supplies in issue. The Hearing Officer found the services/supplies were medically necessary and appropriate medical care and that concurrent care of the administrative psychiatrist and clinical psychologist were required due to the severity and complexity of the beneficiary's illness.

The Director, OCHAMPUS, recommends rejection of the Hearing Officer's Recommended Decision. The Director, OCHAMPUS, concurs, in part, with the Hearing Officer's finding that the drugs and treatment charges may be cost-shared as documented as medically necessary but nonconcurs with the findings that the services of the administrative psychiatrist and the clinical psychologist are documented as medically necessary in toto. The Director recommends cost-sharing of these services only as documented in the medical records and only as daily hospital visits for the services of the administrative psychiatrist. It is the opinion of the Director, OCHAMPUS, that the Recommended Decision fails to

consider prior FINAL DECISIONS of this office on the issue of documentation of medical care and is in conflict with these FINAL DECISIONS. Therefore, the Director, OCHAMPUS, recommends rejection of the Hearing Officer's Recommended Decision and issuance of a FINAL DECISION on the record as indicated above.

Under DoD 6010.8-R, chapter X, the Assistant Secretary of Defense (Health Affairs) may adopt or reject the Hearing Officer's Recommended Decision. In case of rejection, a FINAL DECISION may be issued by the Assistant Secretary of Defense (Health Affairs) based on the appeal record. The Director, OCHAMPUS, has referred the issuance of a FINAL DECISION to this office as the appeal involves a precedential issue of cost-sharing of services of an administrative psychiatrist.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendations of the Director, OCHAMPUS, as noted above. The Hearing Officer's Recommended Decision is, therefore, rejected as not supported by the appeal record and inconsistent with prior FINAL DECISIONS of this office.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) regarding the inpatient psychiatric care at from July 12, 1982, through February 4, 1984, is, therefore, to deny CHAMPUS cost-sharing of the services of the administrative psychiatrist, except as documented in the medical records as daily hospital visits for medication management; to deny cost-sharing of the individual psychotherapy provided by the clinical psychologist, except as documented in the medical records; to deny cost-sharing of individual psychotherapy provided by hospital employed physicians; and to authorize cost-sharing of the drugs and treatment charges except for group therapy not documented in the medical records.

FACTUAL BACKGROUND

The beneficiary was admitted to Hospital, Dallas, Texas, on July 12, 1982, with diagnoses of schizophrenia, chronic, undifferentiated, and schizoid personality disorder. The beneficiary began outpatient psychotherapy with Dr. , a clinical psychologist in 1978. For 6-8 months prior to this hospitalization, the beneficiary had a gradual decompensation. From April 9 through June 28, 1982, he was hospitalized at for psychiatric care.

From June 28 through July 1, 1982, he was treated in the drug treatment program. On July , 1982, he was admitted to Garland Memorial Hospital following auditory hallucinations and trying to eat the foods out of magazines with a spoon. He was transferred to on , 1982.

At transfer, he was being treated with Haldol. Xanax and Congentin. Xanax was deleted upon admission to . In late July 1982, his medications were changed to Trilafon and Benadryl. Valium and Thorazine were also administered during the hospitalization.

The treatment plan included occupational and recreational therapies, family therapy once per week, group therapy, and individual therapy with Dr. once per week beginning September 1982. In late July 1983, the beneficiary began seeing Dr. twice per week at his office off-grounds and was transported by his mother. Dr. did not have staff privileges at and Dr. , staff psychiatrist and an employee of the hospital, provided the services of an administrative psychiatrist throughout the hospitalization. According to Dr. , the administrative psychiatrist does not provide insight-oriented psychotherapy but has daily responsibility for medical and psychiatric decisions, treatment responsibilities, privilege levels, and family interactions. The administrative psychiatrist organizes the treatment team (meeting approximately every two weeks), maintains contact with the family (family therapy is conducted by another staff member), and conducts group process therapy meetings of his twelve administrative patients. Supervision of medication and individual daily rounds are also provided by the administrative psychiatrist. His services are billed in a daily all-inclusive rate by the hospital. Correspondence from Dr. indicates Dr. was selected to provide individual psychotherapy based on his three years outpatient treatment of the beneficiary. However, a treatment model utilizing an administrative psychiatrist appears to be the standard approach at Timberlawn and was not dependent upon 's lack of staff privileges.

Dr. continued individual therapy twice per week until October 1983, when the beneficiary desired a different therapist. Beginning in late November 1983, Dr. began individual therapy. This was discontinued in late January 1984. The beneficiary was discharged on February 5, 1984, with diagnoses of schizophrenia, chronic, paranoid (improved, moderate, with personality structural change) and schizoid personality disorder (improved, slight, with personality structural change). Prognosis was guarded. Discharge was at the request of the beneficiary and his family. Following discharge, the beneficiary attended the day hospital program at from February 8 through March 31, 1984, according to documents in the appeal file. An explanation of benefits form of record in this appeal shows the claims for day hospital services from March 1984 were denied. No explanation of benefit form for the February 1984 day hospital care appears in the file. However, these services are presently not benefits of CHAMPUS and are not in issue in this appeal.

CHAMPUS claims were filed by for the inpatient care provided July 12, 1982, through February 4, 1984, including charges for room and board, drugs and

treatment, supervisory and administrative professional fees, special drugs, recreational supplies, social work counseling, and personal items. Personal items of books and barber services were denied cost-sharing as noncovered services, and appeal was waived at the hearing. Room and board charges, the remaining personal items, social work counseling, recreational supplies, and other miscellaneous charges have been cost-shared by the CHAMPUS fiscal intermediary, Wisconsin Physicians Service. These charges are not in dispute in this appeal. The appeal record contains the opinion of the OCHAMPUS Medical Director indicating that the inpatient level of care was appropriate. Drugs and treatment charges were initially allowed by the fiscal intermediary in the amount of $18,607.88 according to explanation of benefit forms of record. This amount differs slightly from amounts stated in correspondence from the hospital and the attorney for the beneficiary. Charges for the services of the supervisory and administrative psychiatrist were initially denied, except for care on April 26 through May 10, 1983, which was allowed for the billed charge of $630.00. The total amount of these denied charges is $25,020.00 according to the explanation of benefit forms in the record. However, correspondence from the attorney for the beneficiary indicates $19,035.00 is in issue for the services of the administrative psychiatrist. The Hearing Officer adopted the statement from the beneficiary's attorney and apparently did not make an independent analysis. As many of the claim forms are illegible, the best evidence of the amounts billed for services of the administrative psychiatrist are the explanation of benefit forms. The charges for supervisory and administrative professional fees (administrative psychiatrist) range from $35.00 to $55.00 per day including the services discussed above.

Drugs and treatment charges include the services of occupational, recreational and educational therapies, psychiatric medications, and professionally treated group division meetings. These charges range from $29.00 to $35.00 per day and are billed daily as an all-inclusive fee for the above services. The professionally directed group division meetings are essentially patient group meetings on the patient unit conducted by a variety of professional staff according to correspondence from the hospital associate administrator.

Claims were also submitted for individual psychotherapy provided by Dr. , clinical psychologist, from August 2, 1982, through September 27, 1983, in the amount of $2,640.00. These claims were allowed and paid by the fiscal intermediary. As noted above, Dr. provided individual psychotherapy from November 29, 1983, through January 31, 1984. Charges for these services of $1,710.00 were cost-shared by the fiscal intermediary. The beneficiary also apparently received concurrent individual psychotherapy from a hospital physician from August 9 through September 20, 1983. Charges for these services were cost-shared for $442.75 less the beneficiary cost-share.

For clarification, the services and charges in issue are summarized as follows:

- Drugs and Treatment charges July 12, 1982, through February 4, 1984. $18,607.88.
- Administrative Psychiatrist, Dr. , July 12, 1982, through February 4,1984. $25,020.
- Individual Psychotherapy - Dr. , August 2, 1982, through September 27, 1983. $2,640.
- Individual Psychotherapy - Dr. November 29, 1983, through January 31, 1984. $1,710.
- Individual Psychotherapy - hospital physician (name unknown), August 9 through September 20, 1983. $442.75

The beneficiary appealed the initial denial of charges for the administrative psychiatrist, and the fiscal intermediary affirmed the denial upon Reconsideration Review. The beneficiary appealed the denial to OCHAMPUS. The OCHAMPUS Formal Review Decision reviewed the denial of the charges for the administrative psychiatrist, the payment of the drugs and treatment charges, charges for individual psychotherapy by Dr. and by a physician during August/September 1983, and the personal items (books and barber shop charges) mentioned above. OCHAMPUS found the daily charges for the administrative psychiatrist were not medically necessary (considered daily hospital visits) for other than July 12, 19, and 26, 1982, for which documentation existed that the services were performed. Similarly, the psychotherapy services provided by Dr. were denied cost-sharing except on nine dates documented in the medical records. To the extent that Dr. and a physician provided individual psychotherapy concurrently during August/September 1983, the Formal Review Decision found the concurrent care was not medically required and the charge for the physician provided psychotherapy could not be cost-shared under CHAMPUS. Finally, the Formal Review denied cost-sharing of the drugs and treatment charges as itemized services not documented in the medical records as being provided to the beneficiary.

The beneficiary appealed and requested a hearing. The hearing was held on February 21, 1985, at Dallas, Texas, before Sherman G. Bendalin, CHAMPUS Hearing Officer. The Hearing Officer has issued his Recommended Decision and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are (1) whether the services of the administrative psychiatrist provided July 12, 1982, through February 4, 1984, are documented as medically necessary and appropriate medical care; (2) whether the daily drugs and treatment charges are documented as medically necessary care from July 12, 1982, through February 4, 1984; (3) whether individual psychotherapy services provided by the clinical psychologist from August 2, 1982, through September 27, 1983, are documented as medically necessary services; (4) whether the severity and complexity of the beneficiary's illness required concurrent individual psychotherapy from August 9 through September 20, 1983; and (5) whether individual psychotherapy provided by the hospital-employed physician from November 29, 1983, through January 31, 1984, is documented as medically necessary. As four of these issues involve questions of the documentation required to establish medical necessity, the requirements of documentation will be addressed prior to discussion of the separate issues.

Information Necessary to Support CHAMPUS Claims

The Hearing Officer found the documentation provided in the appeal record was inadequate regarding the treatment by Dr. , the hospital-employed administrative psychiatrist. He also recognized in his Recommended Decision that it is CHAMPUS policy, as expressed in FINAL DECISIONS appearing in the record (OASD(HA) File Nos. 83-50, 82-07, 80-09-3), that insufficient documentation may result in denial of cost-sharing. However, the Hearing Officer then states that "whether or not sufficient documentation exists must not cloud the issue which is that the beneficiary required medical care by Dr. while an inpatient." (Recommended Decision, page 9). This statement is not only contrary to the intent of the FINAL DECISIONS directly cited in the Recommended Decision but also directly opposed to two recent FINAL DECISIONS, OASD(HA) File 84-24 (December 5, 1984) and 84-26 (November 27, 1984) wherein exhaustive discussions of the documentation required to establish medical necessity are set forth (see also OASD(HA) Case File Nos. 83-27, 83-10). The Hearing Officer chose to ignore these FINAL DECISIONS and found medical necessity of the services by Dr. and Dr. was established, apparently by testimony. Therefore, I reject the Hearing Officer's findings on the medical necessity of the care provided by Dr. and Dr. as inconsistent with prior FINAL DECISIONS of this office which establish the standard of documentation required for CHAMPUS cost-sharing. As the FINAL DECISIONS cited above contain lengthy analysis of required documentation, the entire discussion will not be repeated herein. In brief, the Department of Defense Regulation governing CHAMPUS, DoD 6010.8-R, requires that private psychiatric hospitals be accredited by the JCAH in order for their services to be cost-shared under CHAMPUS (Chapter VI, B.4.b(2)). Since CHAMPUS requires private psychiatric hospitals

to be accredited by the JCAH, the JCAH standards establish the minimum records necessary for documentation of CHAMPUS claims.

The JCAH's Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities (1981 edition) sets forth specific requirements relating to medical records and progress notes. (Hereinafter, this publication will generally be referred to as the JCAH Manual). The JCAH Manual in the introductory pages titled "using the standards" states:

> "This Manual contains what JCAH currently considers to be the most useful and appropriate standards for evaluating and improving the quality of care provided to . . . child and adolescent psychiatric . . . patients. Except as indicated in the Table of Applicable Standards in Appendix A of this Manual and in the standards themselves, the standards are applicable to all services, units, programs, and facilities providing services to the aforementioned patients."

Standard 15, which deals with patient records, provides, in part:

> "15.1. The facility shall maintain a written patient record on each patient.
>
> "15.1.2. The patient record shall provide information for the review and evaluation of the treatment provided to the patient."

Standard 18.2. addresses progress notes. It provides:

> "18.2. Progress notes shall be entered in the patient's record and shall include the following:
>
> "a. documentation of implementation of the treatment plan;
>
> "b. documentation of all treatment rendered to the patient;
>
> "c. chronological documentation of the patient's clinical course;
>
> "d. descriptions of each change in each of the patient's conditions; and
>
> "e. descriptions of the response of the patient to treatment, the outcome of treatment, and the response of

significant others to important intercurrent events.

"18.2.1 Progress notes shall be dated and signed by the individual making the entry.

"18.2.2 All entries involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed.

"18.2.3 Efforts should be made to secure written progress reports for patients receiving services from outside sources.

"18.2.4 When available, patient records from outside sources shall be included in the patient's record.

"18.2.5 The patient's progress and current status in meeting the goals and objectives of his or her treatment plan shall be regularly recorded in the patient's record.

"18.2.6 The efforts of staff members to help the patient achieve stated goals and objectives shall be regularly recorded.

"18.2.7 Progress notes shall be used as the basis for reviewing treatment plans."

The JCAH Manual defines "shall" as "used to indicate a mandatory standard." The above quoted standards also appear in the 1983 Manual for child, adolescent and adult psychiatric, alcoholism and drug abuse facilities.

The authorities and standards cited/quoted above establish the framework under which both the documentation of medical necessity and the facilities compliance with the standards are reviewed. As documentation is the cornerstone of CHAMPUS (and third-party) reviews, it cannot be divorced from the concept of medical necessity. As adopted by prior FINAL DECISIONS of this office, the medical necessity of the care provided to the beneficiary herein must be reviewed in accordance with the above standards. As noted in the cited FINAL DECISIONS, the "burden of proof" is on the appealing party to affirmatively establish, by substantial evidence, the appealing party's entitlement under law and regulation to cost-sharing. (DoD 6010.8-R, Chapter X; Amendment 19 to DoD 6010.8-R, 48 F.R. 10309 (March 11, 1983)).

Medical Necessity/Appropriate Medical Care
Administrative Psychiatrist

Under DoD 6010.8-R, chapter IV, A.1., CHAMPUS will cost-share medically necessary services and supplies required in

the diagnosis and treatment of illness or injury. Medically necessary is defined as:

> "The level of services and supplies (that is, frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Medically necessary includes concept of appropriate medical care." (DoD 6010.8-R, chapter II, B.104.)

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 or well-baby care, 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." (DoD 6010.8-R, Chapter II B.14)

Regarding services to an inpatient, as relevant to psychiatric care, DoD 6010.8-R provides for benefits for:

> "Inpatient Medical Care. Inpatient medical care means the attending physician's medical (not surgical or maternity) care rendered to an inpatient confined as a bed patient in a hospital or other authorized institution, including intensive or prolonged inpatient medical care, inpatient psychotherapy or inpatient physiatry." (Chapter IV, C.2.c.).
>
> and
>
> "Psychiatric Procedures.
>
> "(1) Maximum Therapy Per Twenty-Four (24) Hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than one (1) hour of

individual and/or group psychotherapy in any twenty-four (24)-hour period, inpatient or outpatient. However, for the purpose of crisis intervention only, CHAMPUS benefits may be extended for up to two (2) hours of individual psychotherapy during a twenty-four (24)-hour period.

"(2) Psychotherapy: Inpatient. In addition, if individual or group psychotherapy, or a combination of both, is being rendered to an inpatient on an ongoing basis (i.e., non-crisis intervention), benefits are limited to no more than five (5) one-hour therapy sessions (in any combination of group and individual therapy sessions) in any seven (7) day period.

"(3) Review and Evaluation: Outpatient. All outpatient psychotherapy (group or individual) are subject to review and evaluation at eight (8) session (visit) intervals. Such review and evaluation is automatic in every case at the initial eight (8) session (visit) interval and at the twenty-four (24) session (visit) interval (assuming benefits are approved up to twenty- four (24) sessions). More frequent review and evaluation may be required if indicated by the case. In any case where outpatient psychotherapy continues to be payable up to sixty (60) outpatient psychotherapy sessions, it must be referred to peer review before any additional benefits are payable. In addition, outpatient psychotherapy is generally limited to a maximum of two (2) sessions per week. Before benefits can be extended for more than two (2) outpatient psychotherapy sessions per week, peer review is required." (Chapter IV,C.2.i)

The CHAMPUS benefit structure provides cost-sharing of medical care provided to beneficiaries by individual providers. There is no separate benefit for the administrative services attendant to the provision of care, and there is no benefit listed for the services of an administrative psychiatrist, as such. Administrative services required in the performance of medical care are included in the allowable charge of the performance of the medical care. Therefore, to constitute CHAMPUS covered benefits, Dr. Brownlee's services provided from

July 12, 1982, through February 4, 1984, must constitute patient care under either or both of the benefits quoted above.

The hearing record establishes the administrative psychiatrist, -- Dr. , -- did -- not provide individual psychotherapy to the beneficiary but, according to his statements, did participate in group division meetings (assumed to be group therapy). While his participation in group division meetings might qualify for cost-sharing as group therapy (subject to documentation required as discussed below), professionally directed group division meetings are included in the inclusive charge for drugs and treatment. Cost-sharing of these meetings will therefore be considered under drugs and treatment.

As stated in the FACTUAL BACKGROUND, Dr. , according to his statements, also supervised the hospital treatment team, maintained contact with the family (but did not conduct family therapy), supervised medication, and made daily rounds. Of these services, only the medication management and daily rounds are services in this appeal that are not duplicated by administrative services attendant to individual psychotherapy. As the clinical psychologist cannot prescribe medication, it is recognized that physician involvement through daily rounds for medication management is required. These services may qualify for coverage under the benefit of inpatient medical care and are cost-shared as daily hospital visits. The beneficiary's attorney apparently accepted the characterization of Dr. 's services as daily hospital visits. Of course, the allowable charge for daily hospital visits is lower than for individual psychotherapy as psychotherapy is of longer duration, and includes greater administrative services, for example. It should also be noted that cost-sharing of the entirety of Dr. 's "supervisory and administrative professional fees" would duplicate, in a large degree, the allowable charge for individual psychotherapy. Therefore, to constitute CHAMPUS covered services, Dr. 's services must be documented as medically necessary daily hospital visits for medication management.

Review of the medical records in this appeal reveals that Dr. wrote numerous and regular orders for medication throughout the hospitalization. However, progress notes were written by Dr. only on July 12, 19, 26, 1982, and January 31, and October 12, 1983. He countersigned other notes; however, the examination of the beneficiary was conducted by an extern. If Dr. Brownlee did not conduct the examination (no patient contact), his services do not qualify as care rendered to the beneficiary. Treatment updates are regular at approximately two week intervals but do not either document his contact with the beneficiary or replace progress notes.

The above quoted JCAH standards clearly demand all treatment be recorded in the progress notes. While daily progress notes may not be required, notes should reflect all treatment rendered. Five progress notes over an 18 month period certainly do not reflect all treatment rendered. Medication orders appear

consistent with applicable standards and are not at issue, but I cannot authorize cost-sharing of daily hospital visits based on physician medication orders. These orders do not fulfill the function of a progress note as stated in the JCAH standards. Additionally, the standards state the progress notes are the basis for treatment updates. In the absence of progress notes, on what basis were the treatment updates made?

While I recognize that Dr. rendered some treatment in this appeal, I cannot "blanket" cost-share services over an 18 month period without documentation that the services were performed. It is incumbent upon the provider to meet the standards of JCAH and establish medical necessity. CHAMPUS is entitled, prior to the expenditure of public funds, to be able to determine if services were provided and whether the services were required. Unfortunately, Dr. did not testify at the hearing, and, therefore, no illumination of his treatment was provided through his testimony. Based on the record, I can only authorize cost-sharing of the services on the individual dates listed above as daily hospital visits.

At the hearing, substantial discussion occurred on the medical appropriateness of the treatment model using an administrative psychiatrist. It is clear that the treatment model of is different from the general model. The OCHAMPUS Medical Director strongly questions this T-A (Treatment-Administrative) split as not a generally accepted medical practice. Dr. indicates in his submissions for the record that this T-A split is based upon the experience at . There is no evidence of record from authoritative medical sources, e.g., major professional medical groups or literature, that this treatment model is a generally accepted medical practice. Therefore, I find the splitting of administrative and treatment duties is not appropriate medical care based on the record in this appeal. Cost-sharing, as above discussed, is on the basis of documented daily hospital visits.

Medical Necessity of Drugs and Treatment Charges

As stated above, the hospital billed a daily charge for drugs and treatment during the inpatient stay of July 12, 1982, through February 4, 1984, rather than itemizing. According to the associate administrator, the drugs and treatment charges include occupational therapy, recreational therapy, educational therapy, psychiatric medications, and professionally directed group division meetings. These charges total approximately $18,600.00 for the entire period of hospitalization.

In my review of the medical records, I find sufficient documentation that drugs were furnished to the beneficiary and that occupational, recreational, and educational therapies were provided routinely. However, no progress notes or other documentation supports the provision of group therapy. The treatment updates do not discuss this therapy or its frequency. The associate administrator states that:

> "Generally speaking, these Professional Directed Group Division meetings are held on a daily basis and [the beneficiary] was involved in these during his hospitalization." (Hearing Record, Exhibit 46, page 2)

It is clear the documentation does not meet the above quoted JCAH standards. There are apparently no notes of discussions held, reactions of the beneficiary, or his progress in treatment arising from group therapy. Again, on what basis are the treatment updates made? The documentation falls far short of meeting required documentation of medical necessity.

The beneficiary's attorney argued that submissions for the record of drug records and monthly notes for occupational and recreational therapies constitute an alternate billing procedure under DoD 6010.8-R, chapter VII, B.2.j. While this FINAL DECISION is based primarily on documentation and not billing solely, the argument is still not relevant. An alternate billing procedure does not replace compliance with JCAH standards. The issue in this appeal is not the billing procedure; the issue is whether the documentation establishes that the services were provided and recorded in accordance with JCAH standards. CHAMPUS will not be forced to accept a billing procedure that is not based on adequate medical documentation. Itemization of the charges would have certainly made adjudication easier and would have resulted in payment of many of the services included in the drugs and treatment charges.

As I have found adequate documentation of all components of the drugs and treatment charges, except the group division meetings, I will authorize cost-sharing the drugs and treatment charges if, within 60 days of the date of receipt of this FINAL DECISION, the appealing party submits a statement of the charges for group division meetings applicable to the beneficiary during the period in issue. In response to the requirement for itemization, the appeal file includes a statement from the hospital associate administrator that it would be impossible for the hospital to state a specific charge for the services covered under drugs and treatment after the patient has been discharged from the hospital. However, as the drugs and treatment charges appear to be "loaded" charges containing all staff salaries, medications, etc. included in the services, I assume the facility established the daily charges on the basis of cost data which could be separated to arrive at a daily or monthly figure, based on average staffing and patient census, for example, for the group division meetings. These charges will be deducted from the total drugs and treatment charges to arrive at the reasonable charges for the drugs and treatment charges for the drugs, occupational, recreational and educational therapies. If the hospital will submit the necessary itemization to the Director, OCHAMPUS, within 60 days from the date of this FINAL DECISION, the claim will be processed in accordance with this FINAL DECISION.

Medical Necessity of the Psychotherapy Provided by Dr.

As discussed above in the FACTUAL BACKGROUND, Dr. submitted claims for individual psychotherapy from August ?, 1982, through September 27, 1983. The record reflects this psychotherapy, one to two times per week, was performed off-grounds at his office. Progress notes appear in the record signed by Dr. on September 7, 14, 20, 21, October 11, 14, 20, and 26, 1982, and March 5, 22, April 18, 24, 1983.

Under the JCAH standards quoted above, a hospital should make efforts to secure written progress notes for patients receiving services from outside sources. There is no evidence the hospital requested progress notes of this treatment in accordance with JCAH standards. Testimony reveals that primary contact between Dr. and Dr. was made by telephone (there is a mention in the treatment updates of difficulty in reaching Dr. Abrahamson by telephone). Apparently, neither Dr. nor Dr. made notes of these conversations, and Dr. did not make notes of his therapy over the one year period of treatment. Dr. testified he only made notes when he observed a change in the beneficiary's condition. This certainly is not in accordance with JCAH standards, and I have denied cost-sharing in appeals where outpatient therapy notes were not maintained as medical necessity had not been established. (OASD(HA) Case File 83-27). Therefore, I find the services claimed by Dr. have not been documented as medically necessary and recorded in accordance with JCAH standards, except on the dates listed above.

Concurrent Care

The Hearing Officer found the severity and complexity of the beneficiary's condition required the concurrent care of both Dr. and Dr. . He and the beneficiary's attorney have misunderstood the concept of concurrent care and the facts in this appeal. The concurrent care challenged by OCHAMPUS does not involve Dr. (he did not provide individual psychotherapy) but concerns the individual psychotherapy provided by Dr. and an unknown physician for which the hospital claimed $442.75 for individual psychotherapy from August 9 through September 20, 1983. There is testimony and file documentation the beneficiary desired another therapist in September 1983. This other therapist, Dr. , treated the beneficiary from November 29, 1983, through January 31, 1984, according to the claims and treatment updates. No mention appears in the medical records of the physician who provided the psychotherapy in August/September 1983 concurrent with Dr. . There are no therapy notes or mention in the treatment updates for this care. Testimony indicates that the hospital was trying to wean the beneficiary from Dr. . That appears to be the reason for the second therapist. There is no discussion in the records of the severity and complexity of the beneficiary's condition that

required two therapists, primarily because the reason was to replace Dr. . While substitution of another therapist may be necessary, CHAMPUS will only cost-share concurrent care under DoD 6010.8-R, Chapter IV C.3(f) if the test of severity and complexity is met.

As there is no evidence supporting the concurrent care and, in view of evidence to the contrary, I find concurrent care was not required, and the services of the hospital physician from August 9 through September 20, 1983, are denied cost-sharing.

Medical Necessity of the Psychotherapy by Dr. and the Hospital Employed Physician

As discussed above, Dr. conducted individual psychotherapy with the beneficiary from November 29, 1983, through January 31, 1984. The records do not indicate if Dr. was the second therapist in August/September 1983. However, the records indicate the hospital had some problem replacing Dr. as the beneficiary had no individual therapy for several weeks.

In reviewing the documentation supporting the claims for Dr. McMillian, I find her claim for services suffers from the same inadequacy as those of Dr. and Dr. . There is no documentation of record except brief mention in the treatment updates. No progress notes appear in the record. Applying the authorities and standards discussed above, I must deny cost-sharing of these services in the billed amount of $1710.00 as medical necessity has not been documented. Similarly, no documentation appears in the record of the services provided by the hospital employed physician from August 9 through September 20, 1983. Therefore, these services, billed in the amount of $442.75, are denied cost-sharing.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is (1) to deny cost-sharing of the services of the administrative psychiatrist from July 12, 1982, through February 4, 1984, except as documented as daily hospital visits on July 12, 19, 26, 1982, and January 31 and October 12, 1983; (2) to authorize cost-sharing of the drugs and treatment charges billed from July 12, 1982, through February 9, 1984, provided the appealing party submits, within 60 days from the date of receipt of this FINAL DECISION, a statement of the charges for group division meetings applicable to the beneficiary, which shall be deducted from the total drugs and treatment charges for cost-sharing; (3) to deny cost-sharing of the individual psychotherapy provided by Dr. Abrahamson from August 2, 1982, through September 27, 1983, except for documented services on September 7, 14, 20, 21, October 11, 14, 20 and 26, 1982, and March 5, 22, April 18, 24, 1983; (4) to deny cost-sharing of the individual psychotherapy, provided by a

hospital employed physician, from August 9 through September 20, 1983, in the amount of $442.75 in billed charges; and (5) to deny cost-sharing of the individual psychotherapy provided by Dr. Berit McMillian from November 29, 1983, through January 31, 1984, in the billed amount of $1710.00. This FINAL DECISION is based on findings the documentation does not establish the medical necessity of the group therapy services of Dr. (except as noted above), of the psychotherapy provided by Dr. (except as noted above), Dr. or the other hospital-employed physician. Further, the documentation does not meet JCAH standards, and the severity and complexity of the beneficiary's condition did not require the services of two therapists during August/September 1983. The claims and the appeal of the beneficiary are, therefore, denied, in part, as set forth above.

The Director, OCHAMPUS, is directed to review the beneficiary's claims and to take appropriate action under the Federal Claims Collection Act to recover any erroneous payments issued in this case. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

William Mayer, M.D.

William Mayer, M.D.

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

Appeal of ,	RECOMMENDED DECISION
Sponsor:	
SSN: 435-44-8134	

This is the Recommended Decision of CHAMPUS Hearing Officer Sherman R. Bendalin in the CHAMPUS appeal case file , and is authorized pursuant to 10 U.S.C. s1071-1089 and DoD Regulation 6010.8-R, Chapter X. The appealing party is the Sponsor, , who was appointed by the Beneficiary to represent him. (Exhibit File, Exhibit No. 22.) (Hereinafter "E. ___.") The appeal involved the denial of CHAMPUS cost-sharing for inpatient hospitalization provided to the Beneficiary from July 12, 1982 to February 5, 1984.

The issues are four in number. The first issue is whether the daily hospital visits provided by the attending physician, , M.D., were medically necessary, appropriate medical care, covered under the CHAMPUS Regulation, DoD 6010.8-R. (Hereinafter "Regulation.") The second issue is whether the individual therapy provided by the psychologist, , Ph. D., may be cost-shared as medically necessary, appropriate medical care. The third issue is whether the patient's condition was of such severity and complexity as to require concurrent care. The fourth issue is whether the drugs and treatment charge represents a medically necessary service or supply, as required by the pertinent part of the Regulation. [A fifth issue, whether the books and barber shop charges are medically necessary services and supplies was waived by the Beneficiary's representative at the beginning of the Hearing and will not be discussed hereafter.]

A hearing was conducted by the undersigned Hearing Officer in Dallas, Texas at the Federal Building, 1100 Commerce Street, on February 21, 1985. The hearing commenced at 9:35 o'clock a.m. and concluded at 1:25 o'clock p.m. Appearing on behalf of the Beneficiary was the Sponsor and the Beneficiary's mother; attorneys , and from , P.C., appeared

representing the Beneficiary and the Sponsor; testifying were , ., the Beneficiary's psychologist Hospital and , Appearing on behalf of OCHAMPUS was attorney/advisor .

The amount in dispute is $41,161.14. (Exhibit 63.) This figure was supplied by Sponsor's counsel subsequent to the Hearing after discussion among the parties during the hearing.

The Hearing file has been expanded to include Exhibits 38 through 64. All Exhibits have been reviewed. The undersigned has reviewed the tape recording of the hearing. The undersigned Hearing Officer, after due consideration of the appeal record, hereby makes the following Recommended Decision on the remaining issues, seriatim. Regarding issue number one, it is the Recommended Decision of the undersigned Hearing Officer that the daily hospital visits provided by the attending physician, , were medically necessary and appropriate medical care thereby qualifying for cost-sharing by OCHAMPUS. As to issue number two, the Recommended Decision is that the individual therapy provided by the psychologist, ., may be cost-shared by OCHAMPUS as medically necessary and appropriate medical care. As to issue number three, the Recommended Decision is that the Beneficiary's condition was of such severity and complexity to justify concurrent care provided to the Beneficiary at Hospital by and . As to issue number four, the undersigned's Recommended Decision is that the drugs and treatment charges do represent a medically necessary service or supply.

FACTUAL BACKGROUND

The Beneficiary was admitted to the on July 12, 1982, where he remained until discharged on February 5, 1984. The Beneficiary had been an inpatient at Hospital for 81 days prior to his admission to . The Beneficiary had a history of gradual psychotic decompensation beginning in 1980. He had exhibited serious potential danger to property and had hinted at the potential danger to himself and his parents prior to admission. (E. 14.) Claims were filed with , for supervisory and administrative charges provided at but were denied. (E. 18.) The initial determination was dated November 19, 1982. (E. 17.) Initial determinations, informal reviews and reconsideration determinations were subsequently made, all continuing to deny the claim of the Beneficiary. The

Beneficiary appointed the Sponsor as his representative on February 10, 1983. (E. 22.) Following the first level decision, dated July 9, 1984, and subsequent action, the hearing request was filed by the Sponsor. Moreover, at issue are possible original decisions which involve the approval of claims which are for the same types of care now being challenged by OCHAMPUS, all of which constitute the amount at issue as set forth.

A Request for Hearing was filed on September 7, 1984 by the Sponsor's attorney, . (E.34.) Prior to the issuance of the Formal Review Decision, this case was previously reviewed by the Medical Director on June 5, 1984. (E. 29.) The thrust of the medical opinion was whether or not enough evidence was provided to verify the medical necessity of services rendered.

The undersigned Hearing Officer has considered Exhibits 1 through 37 which were provided to the parties in the Exhibit file. Additionally, considered and admitted were Exhibits 38 through 64. Exhibit 38 is correspondence from , attorney/advisor, Office of Appeals and Hearings, OCHAMPUS, to the Hearing Officer, undated, submitting documents which were inadvertently omitted from the Exhibit file. Exhibit 39 is a letter to from . Ph. D., dated October 29, 1984, which provides a summary of the Beneficiary's behavior and treatment while at . Exhibit 40 is a letter to from ., dated November 7, 1984, which provides a general summary regarding the Beneficiary's treatment. Exhibit 41 is a letter to from , Chief Appeals and Hearings, OCHAMPUS, dated January 18, 1985, regarding notification of the hearing date, place, time, and Hearing Officer appointed. Exhibit 42 is the Notice of Hearing dated February 21, 1985. Exhibit 43 is a four page memorandum for record, summarizing a case conference with OCHAMPUS Medical Director . and attorney/advisor for OCHAMPUS, which took place January 24, 1985. Exhibit 44 is the six page STATEMENT OF OCHAMPUS POSITION, regarding all of the issues at hand. Exhibit 45 is a summary of the medication record for the Beneficiary during his period of hospitalization at from July 12, 1982 through February 5, 1984. Exhibit 46 is a letter to . from , Associate Administrator, , dated February 12, 1985, regarding the per diem charges for drugs and treatment to all patients. Exhibit 47 is monthly activity progress notes indicating that the patient participated in scheduled daily activities during the period August 13, 1982 through February 5, 1984. Exhibit 48 consists of consultants reports from September 21, 1982 through August 19, 1983. Exhibit 49 are

laboratory reports for the Beneficiary from . Exhibit 50 is a To Whom It May Concern letter from , dated October 3, 1984, regarding three basic daily charges to all patients at the Hospital. Exhibit 51 is a letter to OCHAMPUS from , dated September 19, 1983, objecting to the denial of charges for the Administrative Psychiatrist during the time the Beneficiary was a patient at . Exhibit 52 is a letter to ., CHAMPUS Mental Health Unit, from , dated July 15, 1983, clarifying the hospitalization and treatment of the Beneficiary since March 4, 1983. Also included in Exhibit 52 are letters dated March 4, 1983 and July 14, 1982, respectively, indicating the hospitalization and treatment for the Beneficiary during different time intervals. Exhibit 53 is progress note dated January 25, 1984. Exhibit 54 is a letter to the Hearing Officer from dated February 12, 1985 advising that may be called as witnesses during the hearing. Exhibit 55 is a letter to the Hearing Officer from dated February 18, 1985, advising that he is subpoenaing and to testify on behalf of the Beneficiary at the hearing. Exhibit 56 is a copy of a Final Decision, OASD(HA) Case File Number 80-89-3. (Hereinafter "Final Decision ."") Exhibit 57 is a copy of a Final Decision, Case File Number 82-07. Exhibit 58 is a copy of a Final Decision, Case File Number 83-50. Exhibit 59 is a letter to ., Appeals and Hearings, OCHAMPUS, from , dated February 12, 1985, advising that may be called as witnesses at the hearing. Exhibit 60 is a letter to ., attorney/advisor, OCHAMPUS, and attorney for the Sponsor, from the Hearing Officer dated February 22, 1985, concerning the briefing or comments schedule that was established at the close of the hearing. Exhibit 61 is a letter to the Hearing Officer from , dated March 6, 1985, commenting on Exhibits 45 through 53. Exhibit 62 is a letter to the Hearing Officer from , dated February 28, 1985, which summarizes the Beneficiary and Sponsor's position. Exhibit 63 is a letter to the Hearing Officer from , dated February 28, 1985, which totals the amount in controversy at the hearing. Exhibit 64 is a letter from to the Hearing Officer dated March 8, 1984, in reply to Exhibit No. 61.

ISSUES AND FINDINGS OF FACT

The issues in this appeal remain four in number. As aforementioned, the first issue is whether the daily hospital visits provided by the attending physician, , were medically necessary and appropriate medical

care.

Chapter IV discusses Basic Program Benefits. Section A(1) deals with benefits in general, and reads as follows:

"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.

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 supplies and rental of durable equipment."

Section B(104) of Chapter II defines Medically Necessary, and reads as follows:

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

Chapter II of the Regulation consists of definitions used in the Regulation. Section B(14) defines Appropriate Medical Care, and reads as follows:

"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."

Section G of Chapter IV discusses Exclusions and Limitations. Subsection G(1) defines Exclusions and Limitations, and reads as follows:

"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 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. ..."

As part of the basic program benefits, the professional services benefit is specified at Chapter IV, Subsection C. Specifically, in Section 2, entitled Covered Services of Physicians and Others Authorized Individual Professional Providers, the following definition is found regarding psychiatric services:

"e. Psychiatric Services. Psychiatric services means individual or group psychotherapy."

Also involved is psychiatric procedures, defined in Chapter IV, Subsection C, Professional Services Benefits, Subsection 3, Extent of Professional Benefits which reads as follows:

"i. Psychiatric Procedures.

(1) Maximum Therapy Per Twenty-Four (24)-hour Period: Inpatient and Outpatient. Generally, CHAMPUS benefits are limited to no more than one (1) hour of individual and/or group psychotherapy in any twenty-four (24) hour period, inpatient or outpatient. However, for the purpose of crisis intervention only, CHAMPUS benefits may be extended for up to two (2) hours of individual psychotherapy during a twenty-four (24) hour period.

(2) Psychotherapy: Inpatient. In addition, if individual or group psychotherapy, or a combination of both, is being rendered to an inpatient on an ongoing basis (i.e., non-crisis intervention), benefits are limited to no more than five (5) one-hour therapy sessions (in any combination of group and individual therapy sessions) in any seven (7) day period.

(3) Review and Evaluation: Outpatient. All outpatient psychotherapy (group or individual) are subject to review and evaluation at eight (8) session (visit) intervals. Such review and evaluation is automatic in every case at the initial eight (8) session (visit) interval and at the twenty-four (24) session (visit) interval (assuming benefits are approved up to twenty-four (24) sessions). More frequent review and evaluation may be required if indicated by the case. In any case where outpatient psychotherapy continues to be payable up to sixty (60) outpatient psychotherapy sessions, it must be referred to peer review before any additional

benefits are payable. In addition, outpatient psychotherapy is generally limited to a maximum of two (2) sessions per week. Before benefits can be extended for more than two (2) outpatient psychotherapy sessions per week, peer review is required."

Finally, there is a procedural regulation which is important to this Decision. Chapter X, entitled Conduct of Hearing, at Section D, entitled Hearing, contains several of the procedures applicable to a Hearing. Subsection 11(b) reads as follows:

"11. Conduct of Hearing.

b. Right to examine parties to the hearing and their witnesses. Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination to impeach any witness regardless of which party to the hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by OCHAMPUS at the time of the hearing, or records in the possession of OCHAMPUS, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by CHAMPUS, for the costs or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing."

As the Beneficiary was admitted into , he was under the treatment of Because did not have medical privileges at and because he was not licensed to dispense medication, became part of the treatment team. OCHAMPUS has consistently decided that there was no necessity to have a psychologist such as render psychotherapy to the Beneficiary and, at the same time, have a psychiatrist such as perform what appears to be administrative duties such as organization of the treatment team, overseeing the physical and emotional care of the patient, and coordinating the family and group therapy. (See, for example, Exhibit 44, at pages 3-6.) The regulations cited by OCHAMPUS and their representatives,

which define psychiatric services and psychiatric procedures seem to support the decision of OCHAMPUS.

Nevertheless, it is the opinion of the undersigned that charges were indeed medically necessary and appropriate. care and the charges submitted therefore qualify for OCHAMPUS cost-sharing because and were rendering concurrent medical care to the Beneficiary. [Rational for this decision will be provided in the discussion of issue No. 3, below.]

OCHAMPUS also argues that in most situations, the treating psychotherapist normally performs psychotherapy as well as perform the duties that provided in this case, that is the coordination, supervision, etc. Nevertheless, the undersigned Hearing Officer is pursuaded by the totality of the record that concurrent medical care was justified under the Regulations, and therefore the charges submitted by are payable.

Running through this entire appeal is the issue of documentation. OCHAMPUS has aggressively argued that the documentation requirements to justify cost-sharing of charges were not met. (SEE: Exhibit 58.) It is my opinion that the documentation provided in this file regarding the treatment by is inadequate. Pursuant thereto, the OCHAMPUS Medical Director makes a persuasive point that timely progress notes, made at the time or for that matter made daily rounds, would not have been burdensome, would have been helpful in the treatment regime of the Beneficiary, and would have produced the by-product of being able to provide more documentation to support the instant claim than does exist. (Exhibit 43, page 2.) Nevertheless, in construing the entire regulation, and in combining the regulations concerning psychiatric services, psychiatric procedures and concurrent inpatient medical care [to be discussed and cited more fully in issue No. 3], the undersigned Hearing Officer has become and is persuaded that the medical care rendered by , during his daily hospital visits was indeed medically necessary appropriate medical care. Whether or not sufficient documentation exists must not cloud the issue which is that the Beneficiary required medical care by while an inpatient.

It is the Recommended Decision on this issue, therefore, that daily hospital visits were medically necessary and appropriate medical care.

The second issue in this Hearing is whether the individual therapy provided by ., the psychologist may be cost-shared as medically necessary and appropriate medical care.

The applicable Regulation regarding this issue is found in Chapter IV, Basic Program Benefits. In Section B, Institutional Benefits, at Subsection 2, Covered Hospital Services and Supplies, it is determined that psychological evaluation tests when required by the diagnosis are, indeed, covered hospital services and supplies.

During the Hearing, , appeared and testified. testified that he has a Bachelor Degree in Theology from ; acquired a Masters Degree in Theology in Dallas in 1972; did undergraduate work in Boston; and received his Ph. D. at the 1 of in July, 1978. He testified that he has been a licensed clinical psychologist in the State of Texas since graduation. He has also been in private practice since July, 1978. He testified that he has done life counseling service, has received training in all levels of mental disorder, has had internships in psychiatric hospitals, and has dealt with exposure, treatment planning, supervision, expedition of services all with chronically mentally ill persons.

testified that he had been treating the Beneficiary since 1978. The initial diagnosis was that of grandiosity illusion, bizzare behavior, schizophrenic disorder, and attachment to his therapist. testified that the Beneficiary had a hard time adjusting in public school. Upon his graduation from high school at the age of sixteen he began to display psychotic behavior; he became afraid of functioning, was concerned about nonacceptance by his peers, was further concerned about isolation, and exhibited bizarre activities. first saw the Beneficiary as an outpatient, and last saw him while the Beneficiary was inpatient at . With regard to the treatment at the hospital, testified that all the sessions that he conducted on behalf of the Beneficiary were necessary if not fully documented. Much of the doctor's testimony was based on independant recollection, as there were no additional written notes or records besides those that had been placed in the file and were part of the record. In way of summary, testifed that his continuing treatment of the Beneficiary after the Beneficiary became an inpatient was because had established an interpersonal relationship with the

Beneficiary, that he, was someone the Beneficiary could count on and trust, and that the treatment was necessary to foster and build upon the trust relationship.

CHAMPUS has denied all the claims submitted by except four individual psychotherapy sessions. (Exhibit 44, pages 2 through 3.) The basis for this position is, succinctly, the lack of documentation. It is indeed true that it is CHAMPUS Policy, to the extent that such position has found itself into a Final Decision, that insufficient documentation may result in a Decision to deny cost-sharing a claim filed with OCHAMPUS. (SEE, for example, Exhibit 58.) Nevertheless, based on the entire record, and based on the decision of the Hearing Officer herein that as well as engaged in concurrent medical care, and as such have met all the requirements of the Regulation, it is the Recommended Decision that the individual therapy provided by be cost-shared.

As to the claim set forth in issue number two, it is the Recommended Decision that the individual therapy provided by ., the treating psychologist be cost-shared as medically necessary and appropriate medical care.

CONCURRENT MEDICAL CARE.

The third issue presented in the instant claim is whether or not the Beneficiary's condition was of such severity and complexity as to require concurrent care. As indicated above, it is the Recommended Decision of the undersigned that indeed it was.

At issue herein is that portion of the Regulation defining concurrent inpatient medical care. As part of Chapter IV, Subsection C entitled Professional Services Benefits, Subsection 3(f) defines the extent of professional benefits for inpatient medical care, concurrent, as follows:

> "f. Inpatient Medical Care: Concurrent. If during the same admission a beneficiary receives inpatient medical care (non-emergency, non-maternity) from more than one physician, additional benefits may be provided for such concurrent care if required because of the severity and complexity of the beneficiary's condition. Any claim for concurrent medical care must be reviewed before

extending benefits in order to ascertain the medical conditions of the beneficiary at the time the concurrent medical care was rendered. In the absence of such determination, benefits are payable only for inpatient medical care rendered by the attending physician."

In the opinion of the undersigned hearing officer, this is the pivital issue presented by this claim. It is not documentation, because documentation is something that neither the Beneficiary nor the Sponsor had control over. After all, whether or not or , or either of them or none of them, completed medical records sufficient to meet the requirements of OCHAMPUS is, in the final analysis, something only within the control of the respective doctors or the hospital. If either or both of them have or had sloppy work habits and did not take the time as a qualified professional to document the file or the chart of the Beneficiary while he was a patient at , then they should bear the responsibility for that failure and not the Beneficiary and his family.

It is instructive, therefore, to review the requirements of concurrent inpatient medical care. The Regulation makes no requirement of what is or what is not necessary to provide the necessary documentation. What is required, the so-called "test" for concurrent medical care is whether or not "such concurrent care [is] required because of the severity and complexity of the Beneficiary's condition."

There is nothing in that definition that requires documentation whatsoever. The decision, clearly, is one to be made by the treating physician. Therefore, was the condition presented by the Beneficiary (1) severe and (2) complex enough so that a psychiatrist, and a psychologist, , legitimately treated at the same time and therefore the entire claim for both physicians should be cost-shared by CHAMPUS.

testified on this point. His testimony, summarized greatly, was that a long period of time was required after the Beneficiary became an inpatient for him to be able to be successfully treated by other than because of the long history of treatment that had with the Beneficiary. therefore, was trying to disentagle himself from the treatment of the Beneficiary while a psychiatrist and a person who could prescribe medication, was being eased into the treatment of the Beneficiary. The Beneficiary had and did exhibit resistance towards strangers who attempted to treat him originally.

testified that he was the Beneficiary's "good object." A goal of the inpatient medical care was, therefore, to also qualify as a "good object." As that type of treatment was succeeding, became less and less required in the on-going medical care of the Beneficiary and, conversely, was able to more and more assume the primary treatment and treating role.

During the Hearing, much testimony was received regarding a memorandum of a conference with the OCHAMPUS medical director on January 24, 1985. (Exhibit 43.) A few points from that memorandum deserve mention. First, the OCHAMPUS medical director agrees that the Beneficiary's case was unique because of the interaction between Second, the medical director offers the test for concurrent care being that of absolute necessity for the care of the patient. No citation is given for that test. It is the opinion of the undersigned that the test is not absolute necessity, but rather severity and complexity as found in the Regulation cited above. Third, the medical director goes on to point out a process whereby the treating doctors, as they made rounds, should have in more detail completed the Beneficiary's chart. This point has been discussed earlier and is one I support. He also points out that the actions of other third party payers are of no weight whatsoever with regard to an OCHAMPUS claim. I certainly agree on that point. Finally, the most important issue raised by the medical director, that of "splitting" the personality of the Beneficiary because of two treating doctors was, in my opinion, successfuly rebutted by the testimony given at the Hearing. Succinctly, the treating physicians disagree with that of the medical director. Moreover, it seems to the undersigned that there was agreement between the treatment team and the medical director with regard to the splitting issue; that is, that the splitting phenomenon did not occur in the Beneficiary but, rather, there was a transfer of trust and the treatment ability from to which transfer could not have been accomplished without time and patience.

From the evidence and the record, it is my opinion that if for no other reason than could not prescribe medications at the time the Beneficiary became an inpatient, it was necessary for another physician who had hospital privileges and who could prescribe medication treat the Beneficiary along with who was the person who had the trust and confidence of the Beneficiary. It is my opinion that Exhibit 28, a letter from . does not suggest that the only reason for concurrent medical care at is for one doctor to be the treating physician and the other doctor to act as a coordinator or to counsel the patient's family.

I have also consulted precedential decision OASD(HA) Final Decision 84-33, dated November 27, 1984, on the issue of concurrent care. The Decision is not helpful on the criteria to decide and apply the test as to whether or not concurrent medical care is appropriate.

One other point needs to be discussed. It appears that in Exhibit 44, OCHAMPUS is raising a a sub-issue of medical management. Therein, OCHAMPUS argues that the only adequate documentation from are his progress notes on three days in July in 1982. As I have reasonsed earlier, I support that position. The recommendations of the medical director in Exhibit 43 certainly should be instituted by the provider herein as appropriate. Nevertheless, the argument that documentation is lacking at this point should not prejudice the Sponsor and the Beneficiary.

It is my Recommended Decision that the Beneficiary's condition was of such severity and complexity as to require concurrent care, and that the charges submitted by Doctors should be cost-shared by OCHAMPUS.

DRUG AND TREATMENT CHARGES

The fourth and remaining issue to be resolved in the Recommended Decision is whether the drugs and treatment charges represent a medically necessary service or supply.

Here, again, in the opinion of the undersigned Hearing Officer the real issue is documentation. The reasoning of the undersigned as to the prior issue pertains hereto: that if insufficient, the documentation must not and cannot be used to prejudice the Sponsor and the Beneficiary.

The testimony on this issue is also instructive. , who had no contact with the prescriptions and medication given to the Beneficiary because of licensure requirements, indicated that made all the decisions with regard to medication. Associate Administrator, appeared and testified on behalf of the Sponsor and Beneficiary. testified regarding the preparation of proposed Exhibit 45. The admission of the Exhibit, which was a summary of the medication given to the Beneficiary during the pertinent time, had been objected to. testified at length regarding the preparation of the exhibit. He testified that indeed it was a summary, prepared at his request and under his supervision from the records that had been submitted in support of the Beneficiary's

claim. testified that it was the policy of to give medications only when necessary. He also testified that the charts, upon which Exhibit 45 was based, do not specify who prescribed which medications. Drugs and treatment charges are charged by on a per diem basis. Finally, testified that the fees charged as set forth in the records and in Exhibit 45 were customary, reasonable and necessary as compared to those charged in Dallas County, Texas. Over continuing objection, Exhibit 45 was admitted.

During the post-briefing schedule, OCHAMPUS again raised objections to the admission of Exhibit 45. In Exhibit 61, OCHAMPUS continues to make objections based on relevancy and that the best evidence of these charges are contained elsewhere in the record. During the Hearing, the objections raised were double hearsay and that, again, these were summaries of records contained elsewhere in the Hearing File. Exhibit 45 is in evidence and has been considered by the undersigned.

Exhibit 62 contains the statement of position of the Beneficiary and the Sponsor. Therein, among other things, it was indicated by counsel for the Beneficiary and the Sponsor that proposed Exhibit 45 was prepared, in part, due to a request by the representative of OCHAMPUS. Exhibit 45, therefore, was apparently prepared in response to the request.

Exhibit 45, in the opinion of the undersigned, adequately documents that the drug and treatment charges were medically necessary as a service or supply. If the actual claims cannot be paid as submitted, then it is further the opinion of the undersigned that certainly the provider can be instructed on the proper claim form to use to submit the claim for cost-sharing by CHAMPUS.

With regard to issue number four, it is the Recommended Decision of the undersigned that the drug and treatment charges represent a medically necessary service or supply.

SUMMARY

The issues in this claim are complex and detailed. The Exhibit File when circulated contained 37 exhibits; it now contains 64. Documentation or the lack thereof is a theme common to almost all the issues presented. On the other hand, what was clear from the testimony of the witnesses at the Hearing, particularly the mother of the Beneficiary and the Sponsor, is that the Beneficiary was and

apparantly continues to be a confused young person in need of sophisticated and time-consuming medical care. It also appears that the Beneficiary's medical condition was severe and complex. The use of those particular words, however, are required by the regulation and they fit.

The four remaining issues are decided by the Hearing Officer as discussed above, and as summarized here. The daily hospital visits provided by M.D., were medically necessary and appropriate medical care. The individual therapy provided by , Ph.D., a psychologist should be cost-shared as medically necssary and appropriate medical care. The Beneficiary's condition was of such severity and complexity as to require concurrent care. Drug and treatment charges represent a medically necessary service and supply. Consequently, it is the Recommended Decision of the undersigned Hearing Officer that the denial of CHAMPUS cost-shaing benefits for inpatient hospitalization provided to the Beneficiary from July 12, 1982 to and including February 5, 1984 should be cost-shared, and that the decisions heretofore made by OCHAMPUS in denial of such claim be reversed.

DATED: April 12, 1985.

Sherman R. Bendalin
CHAMPUS Hearing Officer