ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

25 MAY 1988

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

Appeal of (deceased)	)	
Sponsor:	)	OASD(HA) Case File 88-01
SSN:	)	FINAL DECISION

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 88-01, pursuant to title 10, United States Code, sections 1071-1103, and Department of Defense (DoD) Regulation 6010.8-R, chapter 10. The appealing party is the participating provider of care, Geisinger Medical Center, Danville, Pennsylvania. The beneficiary is the deceased son of an active duty member of the United States Marine Corps.

The appeal involves the issue of CHAMPUS cost-sharing of the beneficiary's entire period of hospitalization from March 21, 1984, through April 28, 1985. Specifically, the appeal involves the denial of CHAMPUS cost-sharing for that portion of the inpatient care determined to be custodial care; that is, inpatient care from June 19, 1984, through April 28, 1985, except for care furnished on July 12, 1984, through July 13, 1984; August 3, 1984, through August 13, 1986; and August 22, 1984, through August 23, 1984. The amount in dispute is approximately $242,006.77, and is discussed in greater detail below.

The hearing file of record and the Hearing Officer's Recommended Decision have been reviewed. The appealing party waived the opportunity to present oral testimony before the Hearing Officer and the hearing was held on the written record.

The Hearing Officer found that "[t]he claims for medical inpatient hospitalization provided this beneficiary at the Geisinger Medical Center for the period from June 19, 1984, through April 28, 1985, are precluded from coverage except for the days during which the treatment of medical conditions other than the condition for which custodial care was being provided was present; those days being from July 12 through July 13, 1984, from August 3 through August 13, 1984, and from August 22 through August 23, 1984." In addition, under the CHAMPUS regulation provisions on custodial care, the Hearing Officer found that one hour per day of skilled nursing care and all prescription drugs could be cost-shared under CHAMPUS even on those days of hospitalization which were otherwise denied coverage under the custodial care exclusion.

The Director, Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), concurs with the Hearing Officer's Recommended Decision. The Director recommends its adoption by the Assistant Secretary of Defense (Health Affairs) as the FINAL DECISION with minor modifications related to the amount allowable for skilled nursing services and additional discussion of recent developments pertaining to the CHAMPUS exclusion of custodial care.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, adopts and incorporates by reference the Hearing Officer's Recommended Decision as the FINAL DECISION. In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities and evidence, including authoritative medical opinions in this appeal, and precedent available at the time of the hearing. I have concluded the findings are fully supported in the Recommended Decision and by the appeal record. However, in issuing this FINAL DECISION, I have included minor modifications to the discussion of the amount in dispute and additional remarks concerning recent developments in the CHAMPUS exclusion of custodial care. These developments do not change the result in this appeal but are important in understanding the rationale for the denial of CHAMPUS cost-sharing.

Custodial Care under CHAMPUS

While this appeal was pending, two events occurred which caused a delay in the issuance of this FINAL DECISION. First, on May 15, 1987, the United States Court of Appeals for the District of Columbia Circuit decided Barnett v. Weinberger, 818 F.2d 953 (DC Cir. 1987). The Barnett case reversed a United States District Court decision in which a prior FINAL DECISION in a CHAMPUS hearing case involving custodial care had been upheld. Second, following receipt of the Barnett decision, the

CHAMPUS regulation provisions on custodial care were reviewed, resulting in the publication of a proposed amendment to the regulation in the Federal Register (52 Federal Register 47029) on December 11, 1987.

As stated in the proposed rule, the Department of Defense does not agree with the rationale of the Court in Barnett; consequently, the Court's rationale has not been accepted for application to other custodial cases involving hospitalization. Because the instant appeal is a case in which Barnett could have had an impact, it is important to incorporate our decision on this matter into this FINAL DECISION. The best way to accomplish this is to quote pertinent portions of the supplementary information published with the proposed amendment, as follows:

> "The 1956 legislation which initially authorized civilian health care for military dependents, Pub.L. 84-569, did not contain an exclusion of custodial care. Rather, benefits were more limited. The law excluded domiciliary care and the treatment of nervous and mental disorder, chronic diseases and elective medical and surgical treatments. Power was vested in the Secretary of Defense, after consultation with the then Secretary of Health, Education, and Welfare (currently Health and Human Services), to grant exceptions to these exclusions for up to 12 months of treatment in special and unusual cases. Care in civilian facilities was also generally limited to inpatient treatment for active duty dependents.
>
> "The express purpose of the changes enacted by the Military Medical Benefits Amendments of 1966 was to 'provide improved benefits for military families along the line of those provided other citizens over the (preceding) decade.' Consistent with this intent, the 1966 amendment eliminated the exclusion of the treatment of chronic diseases, representing a significant program expansion. This expansion was tempered, however, by the newly adopted exclusion of custodial care, an exclusion which was also consistent with other public and private health care plans. The custodial care exclusion was intended as a limitation on the expansion of benefits represented in part by the inclusion of the treatment of chronic diseases as a benefit.
>
> * * *

"In developing the 1966 amendments, Congress looked to the Federal Employees' Health Benefits Program for guidance in the development of the benefits package. . . .

* * *

"Historically, the term domiciliary care was defined to encompass the concept of custodial care. In its initial implementation of the 1966 amendments, the Department of Defense derived its definition of custodial care from the one used by the Social Security Administration's Medicare program. A number of custodial care determinations were reviewed under that definition.

"Between 1966 and 1974, CHAMPUS came under increasing Congressional scrutiny and criticism directed at escalating program costs and administrative inefficiencies. A major review was undertaken in 1975-1977 to more consistently enforce the intent of Congress as expressed in the law and to establish a better designed, more uniform program which would be more akin to a contract of insurance and provide a greater degree of control over all program elements. The review culminated in issuance of the comprehensive Department of Defense regulation for the operation and management of CHAMPUS.

"The provisions of the law relating to custodial care and domiciliary care were examined as a part of the comprehensive review initiated in 1975. Based upon the legislative history discussed above, it was determined that these terms actually represent separate concepts and that new definitions were required.

"In seeking a new definition, program administrators looked to the Federal Employee Health Benefits Program (FEHBP). The definition sought had to be easily understood by beneficiaries and providers and had to be workable for the routine processing of claims. The FEHBP provided a reasonable alternative source and was fully compatible with the original intent of Congress in enacting the 1966 amendments. The definition of custodial care ultimately adopted was derived from that source and is consistent with the concepts developed in that program.

"The current custodial care definition has been in effect since 1977.

* * *

"As shown in this historical review, the CHAMPUS custodial care provisions have traditionally acted as benefit limitations to help contain costs in a program that has essentially no limits on medically necessary care and has very favorable cost-sharing provisions. Once a custodial care determination was made, the program offered only limited benefits for the custodial condition. Other third-party plans have controls, absent in CHAMPUS, to contain excessive costs that might otherwise occur with a chronic, long-term illness. These controls consist of limits on the number of days of hospitalization or limits on physician or nursing visits. Some have substantial deductibles and costsharing for inpatient care, and most have either a dollar or a visit limit on other care." 52 Federal Register 47030-47031.

In Barnett, the Court held that the CHAMPUS regulation provision on custodial care was "invalid insofar as it purports to treat medically necessary patient care obtainable only in a hospital as 'excluded custodial care.'" Based on its analysis of legislative history, the Court concluded that "it would be highly anomalous to suppose that by this language (excluding 'custodial care') Congress designed an exclusion of necessary medical services from basic CHAMPUS benefits."

After stating the Court's position, the supplementary information section of the proposed amendment set forth the reasons that the Department of Defense does not accept the Court's rationale. Again, quoting from the proposed amendment:

"The Department of Defense does not agree with the rationale of the Court in this regard. For other reasons, it has chosen not to appeal or seek other relief from the decision. The Court stated that the broad-gaged reading of the statutory exclusion of custodial care is antithetical to the general statutory purpose of enhancing benefits. We do not believe, however, that the Court gave a true picture of the context of the custodial care exclusion. As is clear from the historical discussion above, the 1956 Dependents' Medical Care Act contained an exclusion of domiciliary care. It did not specifically exclude custodial care. Rather, it excluded all care for chronic conditions. This fact was not discussed by the Court. It has significance because it gives a better picture of the basis for the custodial care exclusion in the 1966 amendment.

> "In 1966, Congress removed the exclusion for care for chronic conditions and substituted the exclusion of custodial care. Contrary to the Court's conclusion that the custodial care exclusion did not enlarge the existing exclusion of domiciliary care, what in reality was occurring was that Congress had removed a major exclusion of necessary medical services for those with chronic conditions. Under the 1956 law these conditions were not covered at all, irrespective of how medically essential the care was. The custodial care provision was substituted for this exclusion. For this reason, we disagree with the Court's conclusion that Congress did not intend to exclude CHAMPUS benefits in excluding custodial care. When seen in this context, the custodial care exclusion, as interpreted by the Department in 1977, represents a significant enhancement of benefits over the 1956 law which excluded all care for chronic conditions." Id. p. 47031.

Although the Court's decision in Barnett has been determined to be limited to the Barnett case, other program changes have resulted in a proposal to revise future application of the custodial care exclusion. As stated in the notice of proposed rule, CHAMPUS implemented a new reimbursement mechanism for hospital care (Diagnosis Related Groups of DRGs) effective October 1, 1987. With implementation of DRGs, it is believed that the current custodial care provision would be a duplicative control on inpatient care in acute-care hospitals. Therefore, the proposed amendment would permit coverage of medically necessary and appropriate acute hospital care, which would have otherwise been denied CHAMPUS coverage as custodial care, up to the DRG limit. Even if adopted as a final rule, the proposed amendment would not permit coverage in the instant case because the care in dispute was furnished prior to the effective date of the proposed rule and the implementation date for DRGs.

Modifications to the Hearing Officer's Recommended Decision

The OCHAMPUS Statement of Position, at exhibit 17, page 7, of the hearing record, calculated the amount in dispute. With regard to the 1 hour of skilled nursing care that may be allowed when the care is custodial, the statement said:

> "The one hour per day nursing charge will require calculation according to what is considered appropriate for the geographical area. Thus, the approximate amount that is

> approved for cost-sharing is the total amount actually billed for the days of care approved $104,706.35, plus the amount calculated for 1 hour per day of skilled nursing services ($11,058.71, according to OCHAMPUS calculations), and that amount for covered prescription drugs ($5,005.06, according to the facility's calculations), equaling $120,770.12."

The appealing party, in a letter dated September 25, 1985, exhibit 12, both appealed the Formal Review Determination and set forth what it considered to be the amount in dispute based upon its own calculations and the OCHAMPUS calculations. The provider's calculations relating to skilled nursing services are set forth at exhibit 12, page 6, of the hearing record.

The provider calculated the number of days to which it was entitled to 1 hour per day of skilled nursing services as 297 days; the OCHAMPUS Formal Review calculated it as 331 days. It is determined that the provider's calculation of 297 days is essentially correct; however, it should be adjusted by one day to 298 due to an error in the Formal Review Decision. That is, the Formal Review, as discussed below, miscounted the 90th day of care and excluded care as custodial as of June 20, 1984, rather than as of June 19, 1984, which is the date the Hearing Officer used. This changes the number of days authorized up to 1 hour of nursing care from 297 to 298.

In addition, the Formal Review determined that $33.41 per hour would be the reimbursement rate for skilled nursing services. The provider calculated the skilled nursing charges as $54 per hour.

It was not disputed that the beneficiary's care at the Geisinger Medical Center was medically necessary and at the appropriate level of care. The only dispute was whether the care rendered was custodial care. Therefore, reimbursement for 1 hour of nursing charges would be based not on an outpatient basis but what the provider would normally bill. However, the provider normally billed on a per diem basis for care rendered in the pediatric intensive care unit and did not file claims for nursing charges on an hourly basis. The provider's letter of September 25, 1985, claimed $54 per hour. I find that this is a reasonable charge for inpatient nursing services rendered in a pediatric intensive care unit. In determining reasonableness of charges, geographic location is but one factor to consider. Other factors would include scope of services, level of care and utilization. A pediatric intensive care unit would be a particularly high level of care. Therefore, the $54 per hour for 298 days or $16,092, as set forth in the provider's letter of September 25, 1985, (exhibit 12) is allowable.

In addition to modifying the Hearing Officer's Recommended Decision to accept the provider's calculation of the amount due for skilled nursing care, there is a typographical error to be corrected. On page 6 of the Recommended Decision, it is stated that "treatment provided at the Geisinger Medical Center from March 21, 1984, through April 28, 1984, was medically necessary and appropriate care." The Hearing Officer clearly intended to state April 28, 1985.

Finally, the Hearing Officer's Recommended Decision concluded the care was custodial from June 19, 1984. The Formal Review Decision had found care from March 21 through June 19, 1984, or 90 days could be approved. The 90th day would be June 18, 1984; therefore, the Hearing Officer was correct in recommending exclusion of care as custodial beginning June 19, 1984.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs), is to deny CHAMPUS cost-sharing of the beneficiary's inpatient hospitalization provided at the Geisinger Medical Center from June 19, 1984, through April 28, 1985, as custodial care except for the care provided from July 12 to July 13, 1984; August 3 through August 13, 1984; and from August 22 through August 23, 1984. In addition, for those days for which cost-sharing was denied, 1 hour per day of skilled nursing care is approved for cost-sharing at the rate of $54 per hour. In addition, otherwise covered prescription drugs are approved for cost-sharing for the days denied full CHAMPUS cost-sharing. Therefore, the amount of $104,706.35 previously approved for cost-sharing for those days on which care was not custodial is upheld. Prescription charges of $5,005.06 previously approved for days on which care was found to be custodial are also upheld. The allowable charge for 1 hour of skilled nursing for days found to be custodial is increased from $33.41 per hour to $54.00 per hour for 298 days or $16,092. All other charges for inpatient days involving custodial care are denied CHAMPUS cost-sharing.

Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter 10, and no further appeal is available.

for William Mayer, M.D.

RECOMMENDED DECISION

CIVILIAN HEALTH AND MEDICAL PROGRAM FOR THE UNIFORMED SERVICES

(CHAMPUS)

IN THE APPEAL OF BENEFICIARY:

SPONOR :

SPONSOR'S SOCIAL SECURITY NO.:

PROVIDER : GEISINGER MEDICAL CENTER

This case is before the undersigned Hearing Officer pursuant to a request for hearing made by the provider dated September 25, 1985. The Office of Civilian Health and Medical Programs for the Uniformed Services (OCHAMPUS) has granted this request for a hearing. This hearing was conducted pursuant to Regulation DOD 6010.8-R Civilian Health and Medical Programs for the Uniformed Services (CHAMPUS), Chapter X, Section F, Paragraph 4, Section H, Paragraph 2B.

The Office of Hearings and Appeals, through contacts with the provider determined that it would not be necessary for a formal hearing to be conducted; in that, the provider would prefer a hearing on the record. All evidence having been submitted to the Hearing Officer, the matter is now ready for a Recommended Decision.

OVERVIEW

The record indicates that the beneficiary was enrolled in the CHAMPUS Program being the minor son of an active member of the United States Marine Corps. The beneficiary was admitted to the provider facility on March 21, 1984 and remained there until he expired on April 28, 1985. During said time period, the beneficiary received full inpatient hospital care for which claims for CHAMPUS benefits were filed. Said claims were allowed for services rendered at the facility from the date of admission until June 18, 1984, the initial ninety days of hospitalization.

In response to the sponsor's request for additional benefits under the CHAMPUS Basic Program for said extended inpatient hospitalization, Judy Ritchie, Health Benefits Authorization Specialist of the OCHAMPUS Benefit Authorization Branch, informed

the sponsor by letter dated January 11, 1985 that benefits from June 19, 1984 could not be authorized at the Geisinger Medical Center; in that, custodial care is not a benefit under the CHAMPUS Basic Program.

On February 11, 1985, the sponsor requested an appeal of this determination; said request was acknowledged by Kathy Sharp, Hearings and Appeals Assistant for OCHAMPUS, by letter dated March 4, 1985. On April 5, 1985, Mary Ann Schmitz, an OCHAMPUS Hearings and Appeals Analyst, notified the sponsor that OCHAMPUS would require additional medical documentation regarding the services rendered the beneficiary at the Geisinger Medical Center; she also requested that the information be forwarded to OCHAMPUS as soon as possible. After receiving this additional medical information, OCHAMPUS forwarded same to the Colorado Foundation for Medical Care and requested a peer review which was conducted by Peter S. Quintero, M.D. on July 31, 1985, Ms. Schmitz forwarded the sponsor a copy of the CHAMPUS Formal Review Decision. This decision indicated that CHAMPUS would cost share the first ninety days of service at the Geisinger Medical Center and the periods of service from July 12 through 13, 1984, August 3 through 13, 1984 and August 22 through 23, 1984. It also indicated that one hour of skilled nursing services per day for the remaining periods of hospitalization would also be cost shared, and in addition all of the prescription medications from the period from June 20, 1984 through April 28, 1985 would be cost shared; however, all other claims for services would remain denied.

On September 25, 1985, R.J. Pratt, C.P.A.M., Manager, Business Services for Geisinger Medical Center, requested a hearing on behalf of the provider facility. In said request letter, Mr. Pratt also questioned the amount in dispute and enclosed a detailed breakdown of the facility's calculations concerning the liability remaining for services rendered the beneficiary. Donald F. Wagner, Chief of Appeals and Hearings, acknowledged receipt of the provider's request by letter dated November 14, 1985, requested certain additional information from the provider and set forth procedural information regarding the appeals process. On December 3, 1985, Mr. Pratt forwarded Lisa Turrini, Attorney/ Advisor, Appeals and Hearings, additional medical information and social service notes regarding the beneficiary's case and also indicated that the provider would waive its rights to appear at a hearing and allow the designated Hearing Officer to make a decision on the record.

OCHAMPUS requested an additional peer review conference which was conducted on May 2, 1986 by Mark H. Kogan, M.D. On May 21, 1986, Mr. Wagner's office notified the provider of the designation of the within Hearing Officer and forwarded it a copy of the Exhibit File which included the OCHAMPUS Position Statement prepared by Ms. Turrini.

On May 29, 1986, the within Hearing Officer notified the sponsor of his designation and requested that any additional evidence be submitted within fifteen days after receipt of this notice. Said notice was received on June 2, 1986; no additional evidence was submitted.

FACTUAL BACKGROUND

The evidence contained in the Exhibit File indicates that this two-month old beneficiary was born at thirty-two weeks gestational age and cared for at the provider facility. He had a mild hyaline membrane disease, hyperbilirubinemia, and a Grade I/VI heart murmur. The beneficiary was sent home on an APEA monitor and theophylline, and his mother was instructed in cardio-pulmonary resusciation. Apparently, the beneficiary was doing well at home until the day prior to the admission when after feeding the beneficiary, his mother noticed that all of a sudden, the child arched his back and stopped breathing. His grandmother initiated CPR and the patient was transported to the Lock Haven Hospital Emergency Room by ambulance. During the ambulance trip, the beneficiary required CPR and had full cardiopulmonary arrest upon arrival to Lock Haven. The GMC Life Flight Team was called to transport the beneficiary to the provider facility where an emergency CAT scan of the head was obtained which was felt to be normal without any evidence of intracranial hemorrhage. The initial impressions noted were:

(1) Cardiopulmonary arrest secondary to near miss SIDS versus infantile apnea versus seizures, rule out meningitis, rule out intracranial hemorrhaging (this was basically ruled out by a CAT scan), rule out metabolic disease.

(2) Anemia of unknown origin. Stool is heme negative. OG aspirate was heme negative. Chest X-ray shows no evidence of pulmonary hemorrhaging and the CAT scan was negative for hemorrhage.

The beneficiary was admitted to the Pediatric Intensive Care Unit with a plan for nasal intubation, repeat chest X-rays and abdominal films, maintanence Phenobarbital and Dilantin, Valium as needed, lumbar puncture, neurology consult, continued antibiotic therapy at menigitis doses and a social service consult. (Exhibit 15, Binder 1, Pages 3-5)

During his hospital course, the beneficiary was maintained on Valium, Phenobarbital and Dilantin to control seizure activity. A review of the initial CAT scan showed a small intracerebral hemorrhage at the right posterior parietal area and serial CAT scan showed a deterioration in this condition with obvious intra-parenchymal bleeding of the right hemisphere with shift to the brain to the left; however, no surgery was indicated after consultation.

The child was fed by nasal gastric tube and remained unconscious; he was ventilator dependent. Further CAT scans indicated that he developed a right posterior temporal parietal occipital intracerebral hemorrhage with possible epidural subdural and subarachnoid components. In April 1985, a feeding gastrostomy tube was placed and since the infant did not tolerate ventilatory weaning, a tracheostomy tube was placed without difficulty also in April 1985. During this hospitalization, numerous other consults were obtained regarding neurological, ophtalmological and gastrointestinal problems. Throughout the hospital stay, the beneficiary remained comatose. Rehabilitation consisted of a range of motion program done by the nursing which was sufficient in the absence of severe flexure deformity. The child displayed decerebrate posturing to any stimulation equaling pain and was respirator-dependent. Additional medications were provided during the hospital stay until April 28, 1985 when the patient bradycardiac and expired on said date. (Exhibit 14, Pages 4 and 5)

Prognosis Notes maintained by the provider facility indicates the beneficiary's progress or lack thereof throughout his hospital stay. Said notes were signed by the patient's various attending physicians (Exhibit 15, Binder 1) and state as follows:

> "Unable to effectively wean from ventilator as yet. Will continue attempt." (Page 130, June 18, 1984)
>
> "Unchanged neurologically...will continue to attempt weaning off ventilator." (Page 138, July 2, 1984)
>
> "Weaning of RR (respirator), more difficult now which may mean _ ischemic CNS disease may be progressing." (Page 163, July 30, 1984)
>
> "Condition: Essentially unchanged and remains in coma." (Page 175, August 6, 1984) "Since admission here babe (sic) has never regained consciousness, nor has weaning from respirator been possible. There have been several brief seizure-like episodes an infant on phenobarbital... It is believed infant has suffered severe, irreversible anoxia." (Page 199, August 31, 1984)
>
> "Spoke with father yesterday. He understands that there is no chance of brain recovery." (Page 207, September 7, 1984)
>
> "Spoke at length with patient's grandmother. Explained patient's permanent state of ventilator dependence and lack of any evidence of higher CNS function." (Page 210, September 10, 1984)
>
> "Last CT scan shows diffuse cerebral atrophy. The patient is in permanent vegetative state and is ventilator dependent." (Page 252, October 29, 1984)

"No clinical change. Continues to be in vegetative state." (Page 307, January 2, 1985)

"No change. Continue present management." (Page 322, February 3, 1985)

"Treatment is purely supportive." (Page 333, February 25, 1985)

"S/P cerebral hemorrhage now comatose. Plan: treatment unchanged without complication. Continue present therapy." (Page 338, March 7, 1985)

"Prognosis remains extremely poor." (Page 341, March 16, 1985)

A medical update was also prepared by C.M. Wallace, M.D., Director of the Pediatric Intensive Care Unit for the provider facility. In this report dated December 20, 1984, Dr. Wallace stated that the beneficiary had suffered a severe anoxic encephalopathy which has left him in a persistent vegetative state, that he demonstrates no spontaneous respirations and shows only minimal posturing movements and that he has failed all ventilator weaning attempts. She further stated that this type frequently remains static for many years but that the beneficiary has had repeated episodes of bradycardia during the last six weeks and these are likely indicative of brain stem deterioration which worsens an already completely bleak prognosis. She did not anticipate any major changes in therapy since his condition is unlikely to change significantly. (Exhibit 3, Page 1)

It is also noted that the provider had attempted from May 1984 through August 1984 to arrange the transfer of the beneficiary to a medical facility closer to his parents at Camp Lejeune, North Carolina; however, there were no hospitals willing to accept him on a ventilator. The provider's Social Services Department also indicated that there were no long term care facilities (military or general) in the United States which will admit the beneficiary due to his age and condition. Said Social Service Department also indicated that the beneficiary's parents agreed to having the child be at a Code Level 3 and this was repeatedly explained and clarified that said level meant no cardiac resuscitation. (Exhibit 14, Page 2)

OCHAMPUS requested an initial peer review from the Colorado Foundation for Medical Care. This review was conducted on July 12, 1985 by Peter S. Quinterno, M.D. Dr. Quinterno opined that the beneficiary's inpatient hospitalization was medically necessary from March 21, 1984 through April 28, 1985 for management of his ventilator support, gastrostomy feedings, tracheostomy care, treatment of active medical problems of pneumonia and bradycardia. He also indicated that by June 19, 1984, it was

evident that the patient's disability was expected to continue and be prolonged; in that, the patient remained unconscious and ventilator weaning attempts had been unsuccessful, that the patient required a protected, monitored and controlled environment, that the patient required total support for essentials of life including respiratory assistance and nutrition via a feeding gastrostomy and that subsequent to June 19, 1984 it was unknown whether the medical treatment for this patient could be expected to reduce the disability and enable to the patient to function outside the protected, monitored and controlled environment. The reviewer also noted that other conditions caused complications which would have required hospitalization other than the patient's ventilator dependency for respiratory support; they were on July 12, 1984 the patient had unexplained tachycardia with pulmonary secretions and cyanosis, that chest X-rays were positive for pneumonia, on August 3, 1984 requiring placement on tobramycin through August 13, 1984 and also a brief episode of tachycardia occurred on August 22, 1984 requiring suctioning. He further opined that the beneficiary needed daily physician care, at least one hour of skilled nursing services and medically necessary prescription drugs during his hospitalization. (Exhibit 9, Pages 1-4)

Based upon this consultation, OCHAMPUS indicated in its Formal Review Decision that cost sharing could be approved for the initial ninety days and for the periods from July 12 through 13, 1984, August 3 through 13, 1984 and August 22 through 23, 1984, due to the fact that the beneficiary required acute hospitalization during said periods of time as a result of conditions other than the condition for which custodial care was being provided. Said decision also provided for the allowance of claims for medically necessary prescription drugs and up to one hour per day for skilled nursing services for the periods for which the beneficiary was receiving custodial care. (Exhibit 10)

An additional peer review was conducted by Mark H. Kogan, M.D., also of the Colorado Medical Foundation. Dr. Kogan opined that essentially the beneficiary was never, throughout the whole hospitalization, responsive in any way to multiple attempts at weaning him from the ventilator and that he would be unable to function outside the controlled and monitored environment. (Exhibit 16, Pages 1 and 2) The statement of OCHAMPUS Position, therefore, is that although the treatment provided at the Geisinger Medical Center from March 21, 1984 through April 28, 1984 was medically necessary and appropriate care. The care provided from June 13, 1984 until April 28, 1984 meets the CHAMPUS definition of "custodial care" and as such, is specifically excluded from CHAMPUS cost sharing. Said statement of OCHAMPUS Position also responded to the provider's questions concerning the amount in dispute resulting in a determination of $242,006.77. (Exhibit 17)

ISSUE AND FINDINGS OF FACT

"Whether the medical services and other inpatient hospital care rendered the beneficiary at Geisinger Medical Center, Danville, Pennsylvania from June 20, 1984 through April 19, 1985 was 'custodial care' as defined by the CHAMPUS Regulation?"

Authority

Department of Defense Regulation 6010.8R

Chapter II, B, 14-Appropriate Medical Care
Chapter II, B, 104-Medically Necessary
Chapter II, B, 161-Skilled Nursing Service
Chapter IV, A, 1-Scope of Benefits
Chapter IV, A, 10-Utilization Review
Chapter IV, B, 1-Institutional Benefits
Chapter IV, B, 1f-Institutional Benefits: Services and Supplies
Chapter IV, B, 1b-Institutional Benefits: Inpatient Appropriate Level Required
Chapter IV, E, 12a-Custodial Care
Chapter IV, E, 12c-Custodial Care: Benefits Available
Chapter IV, E, 12d-Custodial Care: Admission to a Hospital
Chapter IV, G, 1-Exclusions and Limitations: Not Medically Necessary
Chapter IV, G, 3-Exclusions and Limitations: Institutional Level of Care
Chapter IV, G, 7-Exclusions and Limitations: Custodial Care
Chapter VII, B, 2j- Patient Treatment Information: Hospitals

Under the provisions of the CHAMPUS Basic Program, an eligible beneficiary may receive allowances for claims for any and all medically necessary services and supplies rendered in the diagnosis and treatment of an illness or injury. This basis payment doctrine, however, as set forth in Chapter IV, Section A1 of the Regulation does indicate that said payment is:

"Subject to any and all applicable definitions, conditions, limitations, and/or exclusions specified or enumerated in this Regulation..."

Medically necessary is defined in Chapter II, Section B104, as that level of services and supplies, (that is frequency, extent and kinds), adequate for the diagnosis and treatment of illness or injury, and further that medically necessary includes the

concept of appropriate medical care. Appropriate Medical Care is defined in Chapter II, Section B14; that portion of this definition which is applicable to the within matter is found in Subsections (a) and (c) which state that the medical care where the medical service is performed in the treatment of a disease or injury are in keeping with the generally acceptable norm for medical practice in the United States, and further specifies that the medical environment in which the medical services are performed must be at the level adequate to provide the required medical care.

Medical services and/or supplies may ordinarily be determined to be medically necessary; however, the twofold requirement that said services and/or supplies also meet the definition of "appropriate medical care" requires that each claim for medical services and/or supplies should be scrutinized to determine that the services and/or supplies were rendered at the level adequate to provide the required medical care. If any medical services and/or supplies rendered are not within the proper level of care, they are determined to be not medically necessary.

It is further stated in Section A10 of Chapter IV of the Regulation that prior to the extension of any benefits under the CHAMPUS Basic Program, all claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for the quality of care and appropriate utilization. The Director is ultimately responsible for setting forth the standard norms and criteria as necessary to assure compliance with this review. Said section specifically states:

> "Utilization review and quality assurance standard, norms and criteria shall include, but not be limited to, need for inpatient admission, length of inpatient's stay, level of care, appropriateness of treatment, level of institutional care required, etc., implementing instructions, procedures and guidelines may provide for retroactive, concurrent and prospective reviews, requiring both in-house and external review capabilities on the part of both CHAMPUS contractors and OCHAMPUS."

This rule clearly establishes a policy wherely OCHAMPUS can determine the need for its medical services and supplies which may be requested under its Basic Program. The normal method by which this is accomplished is through the use of peer reviews. It has been well established that the general medical community has endorsed peer reviews as the most adequate means of providing information and advice to third party payors concerning medical matters which may be in question.

Most of the Basic Program benefits which are included in the Regulation are in Chapter IV, which also contains the

exclusions and limitations. Benefits may be extended to those covered services described in said chapter which are provided in accordance with good medical practice and established standards of quality by physicians and other authorized institutions; however, such benefits are subject to exclusions and limitations as may be otherwise set forth in this or any other chapter of the Regulation. (Chapter IV, Section B, 1) According to Subsections B, 1f and g of Chapter IV, said services and supplies must be rendered in connection with and directly related to a covered diagnosis and/or definitive set of symptoms requiring otherwise authorized medically necessary treatment and at the appropriate level of care required to provide said treatment. Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury are specifically excluded by Section G1 of this chapter as are services and supplies related to inpatient stays which are provided above the appropriate level required; this is indicated in Subsection G3. Custodial care regardless of where rendered except as otherwise specifically provided in Paragraph E 12e of Chapter IV is excluded from coverage under the CHAMPUS Basic Program (Subsection G7 of Chapter IV).

Chapter IV, Paragraph E12a defines custodial care as that care rendered to a patient who is mentally or physically disabled and such disability is expected to continue and be prolonged, who requires a protected, monitored and/or controlled environment whether in an institution or in the home, who requires assistance to support the essentials of daily living and who is not under active and specific medical, surgical and/or psychiatric treatment which will reduced the disability to the extent necessary to enable the patient to function outside the protected, monitored and/or controlled environment. It should be further noted that a custodial care determination is not precluded by the fact that a patient is under the care of a supervising and/or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, and/or provide the patient's comfort, and/or assure the manageability of the patient; further, a custodial care determintion is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N. or L.V.N. Normally, CHAMPUS benefits are not available for services and/or supplies related to a custodial care case; however, as stated previously, Section E12c provides the following exceptions:

1. Prescription Drugs. Benefits are payable for otherwise covered prescription drugs, even if prescribed primarily for the purpose of making the person receiving custodial care manageable in the custodial environment.

2. Nursing Services: Limited. It is recognized that even though the care being received is determined to be primarily custodial, an occasional specific skilled nursing service may be required. Where it is determined that such nursing skills are needed, the benefits may be extended for one (1) hour of nursing care per day.

3. Payment for prescription drugs and limited skilled nursing services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs and limited skilled nursing services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

CHAMPUS benefits may be also available for other covered services or supplies directly related to a medically necessary hospitalization under the following circumstances as set forth in Subsection E12d of Chapter IV. It is indicated therein:

1. Presence of another condition. When a beneficiary receiving custodial care requires hospitalization for treatment of a condition other than the condition for which he or she is receiving custodial care; or

2. Acute exacerbation of the condition for which custodial care is being received. When there is an acute exacerbation of the condition for which custodial care is being received which requires active inpatient treatment which is otherwise covered.

Skilled nursing services which are even a limited benefit in a custodial care situation are defined in Section B161 of Chapter II as services which can only be furnished by a R.N. (or L.P.N. or L.V.N.), and are required to be performed under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, Levin tube or gastronomy feedings, or tracheotomy aspiration insertion. Skilled nursing services are other than those services which primarily provide support for the essentials of daily living or which could be performed by an untrained adult with minimal instruction and/or supervision.

In order to obtain maximum reimbursement for all covered services, a provider must submit an itemized billing showing each item of service and/or supply provided for each day covered by a claim. Chapter VII, Subsection B2j, places this document

requirement upon hospitals and other authorized institutional providers.

The subject matter of custodial care is one which causes a great deal of concern. This is essentially true when said care is being provided in a hospital setting. The fact that custodial care is not a covered benefit under the CHAMPUS Basic Program sometimes becomes misunderstood; in that, beneficiaries, sponsors and/or providers assume that because the custodial care is not covered, it may imply that said care is not medically necessary. This is not the case, it only means that the care itself being provided is not a type of care for which CHAMPUS benefits can be extended. Also, it is not the condition which the beneficiary suffers that is controlling, but whether the care being rendered falls within the definition of custodial care. Since the definition of said care is divided into four basic categories, each should be reviewed based on the circumstances that exist in the present case.

The first portion of the definition is whether the patient "is mentally or physically disabled and such disability is expected to continue and be prolonged". A thorough review of the medical records from the provider facility indicates that the beneficiary remained unconscious and comatose throughout the hospital stay. All attempts at ventilator weaning were unsuccessful; he was respirator dependent. As Dr. Wallace indicated in her memo of December 20, 1984, this type of coma frequently remains static for many years, and as the CHAMPUS Medical Reviewer stated, the patient's mental and physical disability was expected to continue and be prolonged with no indication that the patient would improve. It can be concluded that this beneficiary was mentally or physically disabled and such disability was expected to continue and be prolonged.

The second portion of the definition to be considered is whether the patient "requires a protected, monitored and/or controlled environment whether in an institution or in the home". Basically, from his admission, the medical records indicate that the beneficiary demonstrated no spontaneous respirations and only minimal posturing movements; further, he had failed all ventilator weaning attempts. On three separate occasions, the beneficiary sustained seizures, refractory to therapy and suffered a severe anoxic encephalopaty which left him in a persistent vegetative state. He required medication including anti-infection drugs throughout his hospital stay. It must be concluded as the CHAMPUS Medical Reviewer stated that the record shows that the infant required monitoring and needed a protected environment.

The next portion of the definition to be considered is whether the beneficiary "requires assistance to support the essentials

of daily living". Again, the medical records are replete with indications that the beneficiary received active medical treatment but there was no expected improvement in his condition. The record also indicates his total support for essentials of life including respiratory assistance and nutrition by a feeding gastrosomy; he also required individual personal care such as bathing, skin care, oral care, suctioning and positioning. The CHAMPUS Medical Reviewer opined that the beneficiary required assistance to support the essentials of daily living.

The last portion of the definition to be considered is whether the beneficiary is "not under active and specific medical, surgical and/or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored and/or controlled environment". As Dr. Wallace stated in her medical memo of December 20, 1984 that the beneficiary's repeated episodes of bradycardia during the last six weeks were likely indicative of brain stem deterioration worsens already complete bleak prognosis, and she further stated that she did not anticipate major changes in therapy since his condition it unlikely to change significantly. The Progess Notes from the provider institution constantly reflect the beneficiary's condition as unchanged and not improving in any way. The CHAMPUS Medical Reviewer also stated that although the prognosis was not known, the beneficiary continued to be managed with life support systems without which there would have been no chance of possible improvement. The care received was supportive and mainly supervisory of the activities of daily living.

The care being received by this beneficiary at the provider facility was custodial type care. All the four elements of the CHAMPUS definition of custodial care were present in the treatment rendered this beneficiary. The beneficiary's mental and physical disability was expected to continue and be prolonged. He required a protected, monitored and/or controlled environment. He required assistance to support the essentials of daily living and he was not under any active or specific medical, surgical and/or psychiatric treatment plan which would reduce the disability to the extent to enable him to function outside the protected, monitored and/or controlled environment. As Dr. Kogan of the Colorado Medical Foundation opined:

> It is evident from practically his initial admission date that he was not under any active care which was expected to decrease his disability to the point where he would be able to function outside a monitored and controlled environment and again this is noted multiple times and frequently throughout the chart in terms of notes by the physicians taking care of him as well as nursing notes and the notes for the Social Services Department.

It is, however, noted that at certain times during the portion of the hospital stay which is the subject matter of this hearing, the beneficiary required hospitalization for the treatment of medical conditions other than the condition for which custodial care was being provided. It was noted that on July 12, 1984, the infant had unexplained tachycardia with increased pulmonary secretions and increased cyanosis. He was treated for this condition on said date and on July 13, 1984. He also had an additional sudden onset of cyanosis on August 3, 1984, was bagged and color improved. This condition was treated over the period of the next ten days through August 13, 1984. Again, on August 22, 1984 the patient had a brief episode of tachycardia for which he was treated on said date and on August 23, 1984. For these brief periods of time, the beneficiary required hospitalization for medical treatment of conditions other than those conditions for which he was receiving custodial care and benefits for these time periods would be allowed under the CHAMPUS Basic Program.

Under the custodial care definition, limited nursing services are allowable up to one hour per day; that is, if it is determined that such skilled nursing services are needed. Skilled nursing services are those which can only be furnished by a R.N., L.P.N. or L.V.N. and are required to be performed under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result. The beneficiary did require such skilled nursing services such as intravenous or intramuscular injections, gastrostomy feedings and tracheotomy aspiration and insertion. These skilled nursing serves were greater than those services which primarily provided support for the essentials of daily living and could have been performed by an untrained adult with minimum instruction and/or supervision. The beneficiary did qualify for benefits for skilled nursing services for one hour per day when custodial care was being provided.

The beneficiary also received countless prescription drugs while in the provider facility. These drugs were prescribed by various treating physicians and administered either by the physician under or under his direct supervision. Even if some of these drugs were prescribed primarily for the purpose of making the beneficiary manageable in the custodial and environment, they are covered benefits under the CHAMPUS Basic Program for the period of time in which the beneficiary was receiving custodial care.

In the provider's appeal letter of September 25, 1985, it set forth reasons why CHAMPUS should cost share the hospital services rendered this beneficiary. It indicated that because military medical institutions and other skilled nursing centers would not accept the transfer of this patient, the provider facility had no alternative but to continue treatment. This information is also reflected in a Social Service Consultation dated September 24, 1984 which indicates that efforts were made from May 1984 through August 1984 to arrange the transfer of the

beneficiary to a medical facility closer to his parents, but there were no hospitals willing to accept him on a ventilator. This information is also indicated in the Progress Notes. There are no provisions in the CHAMPUS Regulation for covering medical costs for these reasons. OCHAMPUS is not authorized to cost share medical charges unless the services provided are covered by the Regulation; in this case, the services are specifically excluded by the Regulation.

The provider has failed to meet its burden of proof in the present case. There is no medical evidence contained in the Exhibit File which would indicate that the care provided this beneficiary during the period of inpatient hospitalization from June 20, 1984 through April 28, 1985 was not custodial care as defined by the CHAMPUS Regulation. Although the treatment provided at the Geisinger Medical Center from June 18, 1984 until April 28, 1985 was medically and appropriate, it meets the definition of custodial care and is therefore specifically excluded from CHAMPUS cost sharing.

SUMMARY

As Hearing Officer, the undersigned is authorized to conduct CHAMPUS hearings in compliance with DOD Regulation 6010.8R. Based upon the facts as indicated by the evidence set forth in the Exhibit File and in conjunction with the Regulation, the Hearing Officer must recommend that the determination of OCHAMPUS as set forth in its Formal Review Decision and amended with regard to the amount in dispute in its Statement of OCHAMPUS Position be upheld. The claims for medical inpatient hospitalization provided this beneficiary at the Geisinger Medical Center for the period from June 19, 1984 through April 28, 1985 is precluded from coverage except for the days during which the treatment of medical conditions other than the condition for which custodial care was being provided was present; those days being from July 12 through July 13, 1984 from August 3 through August 13, 1984 and from August 22 through August 23, 1984. In addition, one hour per day of skilled nursing care is approved for cost sharing for the days of care denied full cost sharing and otherwise covered prescription drugs are approved for cost sharing again for the days denied full cost sharing. Further, as determined by the Statement of OCHAMPUS Position, the approximate amount in dispute is the total amount billed $348,876.92, minus the amount approved for cost sharing for hospital charges only $104,706.35 minus the patient's cost share of $2,162.80, resulting in the amount of $242,006.77 should be denied as being not covered benefits under the CHAMPUS Basic Program with the exception of the amount calculated for one hour per day of skilled nursing services and the amount for covered prescription drugs equaling $16,063.17.

VALENTINO D. LOMBARDI, Hearing Officer
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Date: August 15, 1986