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 88-02
SSN:	)	FINAL DECISION

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 88-02, pursuant to title 10, United States Code, sections 1071-1103, and Department of Defense (DoD) Regulation 6010.8-R, chapter 10. The appealing party in this case is the participating provider, Columbus Hospital, Great Falls, Montana, represented by its attorney, Maxon R. Davis, Esquire. The beneficiary is the deceased son of a retired member of the United States Air Force.

The appeal involves the denial of CHAMPUS cost-sharing for an inpatient hospitalization and related medical care at Columbus Hospital from September 21, 1983, through January 12, 1984. The beneficiary was admitted to the hospital September 5, 1983, and after a period of active treatment, was declared clinically brain dead on September 20, 1983. The care from September 21, 1983, to January 12, 1984, was denied CHAMPUS cost-sharing as custodial care except for 1 hour of skilled nursing per day and prescription drugs.

The billed amount for the entire period of care from September 4, 1983, through January 12, 1984, was $155,971.08. Deducting the 25 percent beneficiary cost-share or $38,992.77 and the CHAMPUS payment of $23,790.56 for care from September 5

through September 19, 1983, the amount remaining in dispute is approximately $93,187.75. The amount in dispute is approximate because of possible further reduction by the amount payable for 1 hour per day of skilled nursing care and prescription drugs, to the extent these are not included in the amount already paid.

The hearing file of record, the Hearing Officer's Recommended Decision, and the oral testimony at the hearing have been reviewed. The Hearing Officer has recommended the claims of the provider for inpatient hospital care furnished to the beneficiary from September 21, 1983, through January 12, 1984, be denied CHAMPUS cost-sharing for the reason that the care was custodial care as defined by the CHAMPUS regulation.

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 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 included minor modifications 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.

It is noted that the provider argued, in its closing brief in this appeal, the applicability of several Medicare cases dealing with custodial care. In those cases, as was made clear in the Courts' decisions, custodial care was neither defined by the applicable statute nor by the Medicare regulations. The CHAMPUS regulation specifically defines custodial care and CHAMPUS is administered with that definition, notwithstanding what definition may be used by another federal program. As is noted above in the quotes from the Federal Register notice on the proposed amendment, the definition in the regulation is still considered valid and applicable to the period of time covered by this appeal.

The provider also expressed its view that "the definition of 'custodial care' used in these [CHAMPUS] regulations is couched in language unmistakably contemplating care provided in a convalescent or nursing home setting." (Exhibit 27, page 6) The provider has misread this aspect of the regulation for the reasons quoted above from the proposed amendment. More importantly, it is noted that CHAMPUS does not pay for care at a convalescent center or nursing home under any circumstances; that is, neither convalescent centers nor nursing homes can be CHAMPUS authorized providers. Therefore, it is reasonable to conclude that the custodial care definition was not intended to address only care already excluded from CHAMPUS cost-sharing but to exclude otherwise covered care.

Modifications to the Hearing Officer's Recommended Decision

Amount in Dispute

The Hearing Officer listed the amount in dispute as approximately $131,364.52. It appears that the Hearing Officer calculated the amount in dispute as the total amount billed for the period of care from September 4, 1983, through January 12, 1984, (i.e., $155,971.08) and then subtracted the $23,790.56 that CHAMPUS cost-shared. This is an incorrect statement of the amount in dispute. The beneficiary was a dependent of a retiree. Therefore, assuming the entire amount was deemed to be allowable, the beneficiary would have had to pay a 25 percent cost-share; the remainder (75 percent of $155,971.08 or $116,978.31) would be the maximum that could have been CHAMPUS cost-shared under any conditions. CHAMPUS did pay $23,790.56 for the care from September 4, 1983, through September 20, 1983, plus 1 hour of nursing care from September 21, 1983, through September 30, 1983. This leaves approximately $93,187.75 as the amount in dispute.

Custodial Care - Another Condition or Acute Exacerbation of Condition

The regulation provision dealing with custodial care provides a limited exception for a CHAMPUS coverage of an admission to an acute care hospital for the presence of another condition or an acute exacerbation of the condition for which custodial care is being rendered. (The full regulation provision is set out in the Hearing Officer's Recommended Decision.)

With one exception, the appealing party failed to satisfy its burden of proof on the presence of another condition and/or acute exacerbation of the condition. The beneficiary's heart

failure on January 12, 1984, qualifies as an acute exacerbation of the patient's condition and necessary hospital care for that day may be CHAMPUS cost-shared.

The Hearing Officer did not find there was any treatment for another condition or an acute exacerbation of the beneficiary's condition so as to constitute an exception to the custodial care exclusion. However, I have determined that the beneficiary's heart failure on January 12, 1984, was such a condition and that the care rendered on January 12, 1984, may be cost-shared.

Skilled Nursing Charges and Prescription Drugs

The Hearing Officer recommended that 1 hour of skilled nursing care per day from October 1, 1983, through January 12, 1984, be allowed CHAMPUS coverage. The CHAMPUS fiscal intermediary previously allowed 1 hour of skilled nursing care from September 21, 1983, through September 30, 1983. It is not clear from the record that payment has been made for 1 hour of skilled nursing care per day from October 1, 1983, through January 12, 1984. If not previously paid, it is allowable through January 11, 1984. (See discussion above for care rendered January 12, 1984.) The charges for 1 hour of skilled nursing care are limited to reasonable charges taking into consideration the geographic location of the provider and the level of care, i.e., an intensive care unit. Similarly, any prescription drugs not previously cost-shared from September 21, 1983, through January 12, 1984, are allowable.

Other Health Insurance

The records reflect that the injuries to the beneficiary were caused by an automobile accident. In most instances, accidents involving motor vehicles are covered by automobile insurance that provides medical coverage. Such medical coverage is considered other health insurance within the meaning of the CHAMPUS regulation and would be primary payor to CHAMPUS. The appeal file does not show whether or not there was other health insurance. Any reprocessing of claims or adjustments by the fiscal intermediary will have to verify whether or not there was other health insurance coverage and, if so, the appropriate amount payable under CHAMPUS as secondary payor.

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 hospital care and related services from September 21, 1983, through January 11, 1984, as custodial care,

except that 1 hour of skilled nursing care per day and prescription drugs from the period September 21, 1983, through January 11, 1984, are allowable. In addition, the care for January 12, 1984, may be CHAMPUS cost-shared as treatment for a condition other than the condition for which custodial care was being rendered.

The appeal record indicates that the CHAMPUS fiscal intermediary initiated recoupment for erroneous overpayments; however, it is not clear whether the payments were recouped. Therefore, if recoupment has not been completed, and the amounts payable under this FINAL DECISION are less than the amounts previously paid, then appropriate action will be taken under the Federal Claims Collection Act to recover any remaining overpayments. It is also noted that the record does not reflect whether there was any coordination of benefits with other health insurance including medical coverage from a motor vehicle insurance policy. In processing claims, the fiscal intermediary will take steps to assure appropriate coordination with other health insurance.

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

for William Mayer, M.D.

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

Appeal of	)	
	)	
Sponsor:	)	RECOMMENDED
	)	DECISION
SSN:	)	

This is the Recommended Decision of CHAMPUS Hearing Officer C. D. Heidgerd in the CHAMPUS appeal case file regarding the above-named beneficiary, and is authorized pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the provider, Columbus Hospital, Great Falls, Montana, which provided the care of the beneficiary, who is deceased. The sponsor was the father of the beneficiary and who was otherwise eligible to receive CHAMPUS cost-sharing benefits for him and his dependents.

The appeal involves the denial of CHAMPUS cost-sharing for care provided to the beneficiary by the provider from September 21, 1983, through January 12, 1984. The amount in dispute is approximately $131,364.52.

The Hearing file of record has been reviewed. It is the OCHAMPUS position that the Formal Review decision, issued September 12, 1985, denying CHAMPUS cost-sharing for the care in dispute should be upheld. The reason for the OCHAMPUS position is that the care provided by the hospital was custodial care and is therefore specifically excluded from CHAMPUS coverage. The appealing party's position was that the care was not custodial but was hospitalization as defined in 10 U.S.C. 1077(a)(1) and not custodial care and is therefore included for coverage under the CHAMPUS program.

The Hearing Officer, after due consideration of the appeal record, including testimony presented by the appealing party and its additional exhibits, and after due consideration of its post-hearing memorandum, concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing.

The Recommended Decision of the Hearing Officer is, therefore, to deny cost-sharing for the care of the beneficiary at the provider hospital from September 21, 1983, through January 12, 1984. The reason for the decision is that the appealing party did not affirmatively establish by substantial evidence that the care in question was not custodial care within the meaning of the CHAMPUS regulations and by prior precedential CHAMPUS decisions. Because the case was custodial, CHAMPUS benefits are excluded from cost-sharing.

FACTUAL FACKGROUND

The beneficiary, at the time he received his fatal injuries, was 13 years old. He was injured as a result of being thrown from an automobile on September 5, 1983.

The child was taken after his accident unconscious to the emergency room of the provider in Great Falls, Montana where a physical examination and a CT scan revealed serious and obvious head injuries. On that same day, he underwent an emergency craniotomy. The child was still comatose but stable on September 8, 1983, and he was again operated on to repair his facial injuries. At that time, he also received a tracheostomy.

The child's injuries included serious brain injuries and he incurred considerable cerebral hemorrhaging. The child actually never regained consciousness after his accident and was kept in the provider's intensive care unit at all times where he was maintained on ventilator support and fed by means of a tube.

On September 20, 1983, after conducting standard tests, including a series of EEG's, the child's attending and treating physicians determined that the child was clinically brain dead. Even so, the child's mother and father refused to accept this diagnosis. The child's parents continued to note muscle contractions in his arms and legs when they touched him and viewed those reactions as evidence of cerebral activity.

Although the child's treating physicians recommended removing the child's life support systems, his parents refused to authorize such removal. Not only did the child's parents never authorize the provider to disconnect him from the life support systems, they insisted that physical therapy be undertaken. The child's mother even insisted that headphones be put on her son with hope that his listening to music would prove rehabilitative.

Because the child was clinically brain dead, he was in an irreversable coma. Furthermore, if the ventilator and life support systems were removed, the child would have physically died before January 12, 1984. However, considering the parents' refusal to remove the life support systems, the provider and the child's attending and treating physicians determined that the child would remain in the intensive care unit. Moving him to a private room, although medically conceivable, was not feasible because of the lack of private duty nurses in the area in question. Even so, leaving the child in the intensive care unit was appropriate, according to the child's treating physician, because of the parents' attitude toward removing the life support systems.

As a result of his being clinically brain dead, the child suffered from a number of other medical problems that required and received active medical intervention. These problems included respiratory and urinary tract infections, hypotension (low blood pressure), diabetes insipidus coupled with severe hyponatremia, anemia and pheumonitis.

While these conditions were medically distinct problems and were treated separately, the conditions also would not have occurred but for the child's cerebral injuries and his being clinically brian dead.

The child finally died on January 12, 1984, as a result of a drop in his blood pressure leading to cardiac arrest.

Several claims for the child's care were filed with the CHAMPUS fiscal intermediary beginning in November, 1983, in which some of the claims were allowed and others denied.

The Final Decision by the fiscal intermediary as to the claims was made on October 12, 1984, in which it allowed cost-sharing for the active medical care for the period September 5, 1983, through September 20, 1983, but it denied those claims for care provided after September 20, 1983.

A request for review of the denial was made on November 28, 1984, for OCHAMPUS to make a formal review. The OCHAMPUS Formal Review was made on September 12, 1985, and held that except for limited nursing services and prescription drugs, the care of the child after September 20, 1983, was custodial in nature and not compensable by CHAMPUS.

The total amount of the claim for care from September 5, 1983, through January 12, 1984, was $155,971.08. CHAMPUS has paid a total of $56,848.69 but is now claiming that it has over paid the provider in the amount of $32,242.13. The total amount of the claim in dispute, then, is $131,364.52.

In apt time, a request for another appeal and another hearing was requested by the provider.

As a result of the request, Notice of Hearing was given for January 10, 1986, at 9:30 a.m. with all defects in the timeliness of the notice being waived by the provider.

The hearing was held on January 10, 1986, before OCHAMPUS Hearing Officer C. D. Heidgerd. The provider was represented by counsel and introduced two witnesses and four additional exhibits including three discharge summaries and the final patient charge. After the hearing, the attorney for the provider submitted a post hearing memorandum which was marked as an exhibit also.

ISSUES AND FINDINGS OF FACT

The primary issue in this appeal is whether or not the care provided the beneficiary by the provider from September 21, 1983, through January 12, 1984, was custodial care as defined by CHAMPUS regulations and as defined by 10 U.S.C. 1077(b)(1). A secondary issue is that, assuming the care of the beneficiary was custodial in nature, did the beneficiary either require hospitalization for treatment of a condition other than the condition for which he was receiving custodial care or was there an acute exacerbation of the custodial care condition and thereby entitled to compensation for those services.

LAW AND REGULATIONS - BENEFITS COMPENSABLE

The United States Congress, in Title X, United States Code, Chapter 55, determined that it would provide for ". . . an improved and uniform program of medical and dental care . . ." for the Uniformed Services, former members of the services and for their dependents. (Hereinafter CHAMPUS Program) 10 U.S.C. 1071. However, Congress did not intend for all medical and dental care for the named beneficiaries to be compensated under the CHAMPUS Program, but only certain care. Specifically, Congress determined in 10 U.S.C. 1076 that dependents would be covered in the CHAMPUS Program and that, as set forth in 10 U.S.C. 1077:

> "(a) Only the following types of health care may be provided under section 1076 of this title;
>
> (1) Hospitalization.
>
> * * *
>
> (b) The following types of health care may not be provided under section 1976 of this title;
>
> (1) Domiciliary or custodial care."
>
> * * *

Furthermore, Congress delegated to the Secretary of Defense, the Secretary of Transportation and the Secretary of Health and Human Services to administer the medical and dental care program and to provide joint regulations for the program. 10 U.S.C. 1073-1074. The Secretaries have enacted regulations for the medical program which are hereafter denoted as CHAMPUS regulations.

Congress has specifically excluded custodial care from CHAMPUS coverage (10 U.S.C. 1077(b)(1)) and the implementing CHAMPUS regulations also exclude custodial care. DoD 6010.8-R, chapter IV.G.7. states as follows:

> "Custodial Care. Custodial care regardless of where rendered except as otherwise specifically provided in paragraph E.12.e. of this Chapter IV."

Custodial Care is defined twice in the CHAMPUS regulations, the first definition is found in DoD 6010.8-R, chapter II.B.47. as follows:

> "47. Custodial Care. 'Custodial Care' means that care rendered to a patient (a) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (b) who requires a protected, monitored, and/or controlled environment whether in an institution or in the home, and (c) who requires assistance to support the essentials of daily living, and (d) who 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, minitored, and/or controlled environment. 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 for the patient's comfort, and/or assure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N. or L.P.N."

"Note: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under the CHAMPUS Basic Program."

Custodial care is also defined in chapter IV of the CHAMPUS regulations concerning basic program benefits. In DoD 6010.8-R, chapter IV.E.12.a., custodial care is similarly defined as follows:

"12. Custodial Care. The statute under which CHAMPUS operates specifically excludes custodial care. This is a very difficult area to administer. Further, many beneficiaries (and sponsors) misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Definition of Custodial Care. Custodial Care is defined to mean that care rendered to a patient (1) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored and/or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who 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. 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 for the patient's comfort, and/or assure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a R.N., L.P.N, or L.V.N.

b. Kinds of Conditions that Can Result in Custodial Care. There is no absolute rule that can be applied. With most conditions there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases might be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or pre-senile and senile dementia. These conditions do not necessarily result in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling but whether the care being rendered falls within the definition of custodial care."

Not all benefits are excluded for a beneficiary receiving custodial care. For example, CHAMPUS benefits are available for certain prescription drugs and limited nursing services in connection with a custodial care case. DoD 6010.8-R, chapter IV.E.12.c. In fact, in the case file at hand, these limited benefits were approved in the Formal Review Decision. (See Exhibit 17)

Also, under certain circumstances, CHAMPUS benefits may be available for certain admissions to a hospital. DoD 6010.8-R, chapter IV.E.12.d. provides these exceptions for a beneficiary receiving custodial care as follows:

"d. Beneficiary Receiving Custodial Care: Admission to a Hospital. CHAMPUS benefits may be extended for otherwise covered services and/or supplies directly related to a medically necessary admission to an acute care general or special hospital, under the following circumstances:

(1) Presence of Another Condition. When a beneficiary receiving custodial care requires hospitalization for the treatment of a condition other than the condition for which he or she is receiving custodial care (an example might be a broken leg as a result of a fall); 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."

Furthermore, it must be emphasized that at the contested case hearing level, the burden of proof is on the appealing party to prove its entitlement under the CHAMPUS program and not on OCHAMPUS to prove otherwise. The CHAMPUS regulations, in two instances specifically hold that:

"The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of CHAMPUS benefits or approval as an authorized provider." DoD 6010.8-R, chapter X.A.3. and D.11.C.

Also, in making the determination in a contested case, the Hearing Officer must use prior CHAMPUS final decisions as precedent. For example, the CHAMPUS regulations provide for appeal and hearing procedures and provide for the making of final administrative decisions. Under certain circumstances, final decisions and contested hearings are made by the Assistant Secretary of Defense (Health Affairs). When these final decisions are made by the Assistant Secretary or his designee, the final decision ". . . may be relied on, used, or cited as precedent in the administration of CHAMPUS." DoD 6010.8-R, chapter X.E.2. Also, the Hearing Officer, notwithstanding his personal views, ". . . may not establish or amend policy, procedures, instructions or guidelines." DoD 6010.8-R, chapter X.D.6.

HOSPITALIZATION

The provider has contended in its post memorandum brief that because the child was hospitalized in an acute care hospital during the time in question, such care was hospitalization within the meaning of 10 U.S.C. 1077(a)(1). The provider also contends that the actual care the child received in the acute care hospital was the appropriate level of care for his injuries and was medically necessary. As such, because the care was appropriate and necessary hospitalization Congress intended to provide CHAMPUS benefits for the beneficiary. The essence of the provider's contention is that once it is determined that the appropriate level of care for a beneficiary is hospitalization, then it is covered and not excluded because the care also happens to be custodial care specifically excluded by 10 U.S.C. 1977(b)(1).

The OCHAMPUS position is simply that notwithstanding whether or not the appropriate level of care may or may not be hospitalization within the meaning of the approprite statutes and regulations, if the care also is custodial, the benefits are excluded absolutely for this care. In other words, if care is custodial, it makes no difference whether or not it is hospitalization or not.

There are at least two prior precedential final decisions which, although not specifically addressing the issue raised by the provider, do support the OCHAMPUS position. The first Final Decision, Case File 84-11, decided January 22, 1985, involves the issue of whether or not an extended period of time by the beneficiary in a nursing home was custodial in nature. The Hearing Officer, in his Recommended Decision, had an extended discussion of the medical necessity, appropriateness, and the level of services necessary for the beneficiary. However, in the Final Decision, the Assistant Secretary of Defense (Health Affairs) said that such extended discussion was unnecessary ". . . because of the finding made herein that

the care provided to the beneficiary was primarily custodial. . ." Id. p. 9 If the care was custodial, the decision held, the benefits were excluded. Thus, in this case, it made no difference whether or not the care was appropriate or not if the care was custodial.

In another Final Decision, Case File 84-22, decided October 25, 1984, the beneficiary was a patient in a general hospital and suffered from a rare and difficult illness which was terminal. The Assistant Secretary of Defense (Health Affairs) adopted the Hearing Officer's Recommended Decision which held that the care in the hospital, which included the need for "life support functions," was custodial in nature and excluded from CHAMPUS benefits.

The reasoning of the two precedential final decisions is that if the case is custodial, CHAMPUS benefits for the care is excluded notwithstanding whether or not it was also hospitalization.

The provider also contends that the terms hospitalization and custodial care as used in the enabling statute and CHAMPUS regulations are mutually exclusive. That is if care was determined to be hospitalization authorized for reimbursement under 10 U.S.C. 1077(a)(1), it cannot logically be viewed as being excluded for reimbursement as custodial care under 10 U.S.C. 1077(b)(1). In other words, care cannot be included and excluded at the same time. Furthermore, the provider also contends that the implementing regulations contemplate custodial care being provided only in convalescent or nursing home settings and not in hospital settings.

While custodial care certainly is usually given in a setting other than an acute care hospital setting, and while the rules may certainly appear to contemplate such a nursing home setting, it does not follow that custodial care in a hospital cannot also be considered custodial care. If the care in question meets the definition of custodial care as set forth in DoD 6010.8-R, chapter IV.E.12.a. and b., the care is custodial care, notwithstanding where it is given. Care can be appropriately both hospitalization and custodial at the same time. I find that the terms hospitalization and custodial care are not mutually exclusive and that custodial care certainly can be given in a hospital setting and certainly is excluded from CHAMPUS cost-sharing benefits.

The issue, then, based upon the reasoning of the two cited final decisions and upon logical reasoning, is not simply whether the care is hospitalization or not; the issue is whether such care is custodial and excluded from CHAMPUS benefits under the appropriate law and regulations. I find, then, that just because the beneficiary may have been appropriately hospitalized does not mean that automatically CHAMPUS cost-sharing benefits are available. The care in question must be scrutinized to determine whether or not the hospital care in question was custodial.

CUSTODIAL CARE - DISABLED AND PROLONGED

Medical care that is considered custodial as defined by the CHAMPUS regulation is not available for CHAMPUS cost-sharing benefits. And medical care is custodial if it is rendered to a patient who:

(1) is mentally or physically disabled and such disability is expected to continue and be prolonged, and

(2) requires a protracted, monitored and/or controlled environment whether in an institution or in the home, and

(3) requires assistance to support the essentials of daily living, and

(4) 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. DoD 6010.8-R, chapter IV.E.12.a.

The provider concedes that the beneficiary on September 20, 1983, met parts 2, 3, and 4 of the custodial care definition. However, the provider contends that the beneficiary was not physically disabled and, even if he was considered to be disabled, the disability was not expected to be prolonged.

The provider, in essence, contends that brain death is not a disability because it is different from a disability in that it "transcended disability and was something far beyond what the regulations contemplated, in their discussion of 'custodial care.'" See Exhibit 27, p. 8. It seems that the contention is that because the diagnosis of brain death is more serious than a disability, it should not be considered as a disability within the meaning of custodial care in the CHAMPUS regulations.

While it is true that the CHAMPUS regulations do not define the term disability, the term is generally used both in medicine and in law. The term is defined by Taber's Cyclopedic Medical Dictionary, 13th Edition (1978) (F. A. Davis Company) as follows:

> "Disability. Lack of ability to perform mental or physical tasks which one can normally do. The term is used in legal medicine to apply esp. to the loss of mental or physical powers as a result of injury or disease. See: Handicap."

There is no question that the child, after September 20, 1983, was clinically brain dead. His brain simply was not functioning. He could not perform any mental or physical tasks.

Dr. T. E. Harper described the child's lack of brain functioning in his discharge summary dated October 27, 1983. (Exhibit 23) He writes:

> "Problem Number 3 - Clinical Brain Death: On the morning of 9/12/83, the patient was noted to be at 0615 to be unresponsive to painful stimuli and to have pupils that were fixed and dilated at 7mm. . . . Dr. Thomas Harper of pediatrics was called for consultation at 0900 for further evaluation and

management. The condition of the patient was said to be unchanged. . . .

* * *

On 9/13/83, an EEG was obtained which was characterized by continuous slowing of rather high amplitude perhaps of one to four cycles per second. All the present bilateral slowing seemed to be more prominent on the left side, perhaps more so on the left frontal temporal region. The EEG was said to definitely argue against the presence of cerebral death at that time. . . .

* * *

After the acute episode, the patient never again developed reactive pupils. At first they would at times be smaller but not obvious reactive, at times right was greater than left. . . . On 9/14/83, another EEG was performed and revealed moderate to generally high voltage arrhythmic delta activity with a small amount of some lower voltage arrhythmic theta components. . . . The EEG was therefore considered abnormal but definitely not brain dead. On 9/14/83, the patient was weaned off controlled ventilation, placed on a T-piece. Shortly thereafter, he ceased respirations and had increased blood pressure and pulse. He was bagged and immediately resumed spontaneous breathing, was placed back on artifical respiration. By 9/15/83, the patient had decreased his respiratory rate and only was breathing at the minimal IMV rate of 5 and ultimtely had to be put back at an IMV rate of 20. Thereafter, he had no further spontaneous respirations. He continued to have some reflex responsiveness in his lower extremities but no purposeful movement. His pupils remained fixed and dialated. Another EEG was performed 9/16/83 and revealed some relatively diffuse five or six cycle per second activity suspected to be artifactual. In bipolar recording runs an essentially flat tracing was obtained from all lead areas except for some low amplitude activity from the frontal region. . . . Finally on 9/19/83, the patient had another EEG performed in the ICU. The measured portions of that record were essentially flat except for some nondescript baseline wondering, but there continued to be some low voltage ripple of the data frequency as best seen on the right side. This was consistent in at least two readings. This was essentially the same as the record of two days previously. It was suspected that this was probably artifact. On 9/20/83, a repeat EEG was performed in the EEG lab in the hopes of ruling out any artifacts from the ICU. There is noted to be considerable semi-rhythmic baseline irregularity clearly related to the respirator. Except for isolated electrode artifact, the record was considered isoelectric with only faint baseline wondering when the respirator was turned off briefly. Even at increasing gain setting, no activity consistent with cortical origin was detected. This EEG was considered flat line and consistent with cerebral death. . . .

> Detailed discussions were held on numerous occasions with the parents to discuss his management and the apparent nature of his brain death clinically. At the parents' request, on 9/17/83, a second neurosurgeon . . . was called for a second opinion regarding cerebral death. He confirmed the lack of spontaneous respirations, the fixed and dilated pupils with no occulocephalic help, no response to pain. No movements in the upper extremities to painful stimuli but some foot movements in response to pain in the palms. There was actual withdrawal movement on either side. There was deep tendon reflexes in the upper and lower extremities, slightly atypical in the upper extremities. . . . It was noted that the more prominent signs of brain function were not present in the patient and the ultimate prognosis was that probably complete cerebral death would insue in the near future. . . .
>
> Most likely at the present time, he has no cerebral prefusion at all. Again, throughout the weeks, the parents were constantly informed of the patient's clinical brain death and the lack of realistic outlook. However, both parents remained firm in the decision not to desire termination of support."

Based upon the provider's own evidence, it was clear to all that the child could not perform any mental or physical tasks because of being clinically brain dead. Without question, I find that clinical brain death is a disability within the meaning of the CHAMPUS regulations.

The provider further contends that, even if clinical brain death could be viewed as a disability, the disability could not be considered to be prolonged because there was no indication in the record as to the length of time the beneficiary would be expected to be in the brain dead condition.

This issue has been raised before in the File Final Decision, Case File 84-11 and the Hearing Officer in that case file agreed with it. The Hearing Officer in Case File 84-11 proposed a rule that there must be some evidence in the record of the life expectancy of the beneficiary to determine whether or not a condition or disability would be prolonged.

However, the Assistant Secretary of Defense (Health Affairs) overruled the Hearing Officer and rejected the Hearing Officer's recommendation on the prolonged issue. The decision in Case File 84-11 held that to determine whether a disability is prolonged or not ". . . it must be determined whether the disability is likely to exist over a substantial portion of the duration of the beneficiary's illness, irrespective of how long that may be."

In the case file in question, the beneficiary's primary illness was clinical brain death and clinical brain death was irreversible. By letter dated December 12, 1983, Dr. Thomas E. Harper wrote that the beneficiary was diagnosed as having, among other things, "irreversible coma with clinical brain death . . ."

He also wrote that:

> "As noted, patient's initial trama and ultimate course have left him in an irreversible coma. His parents have refused to allow termination of ventilator support. In response to their wishes, he is being given continued supportive care. If there is never any termination of his ventilator support, at some point he will no doubt succumb to pulmonary complications. It is not possible to predict how long this will be, with any degree of certainty." Exhibit 5

In his final discharge summary, Dr. Harper wrote:

> "Problem Number 1 - Brain Death. There was never any change in the patient's neurological status. Consultation at the parents' request by Dr. Tacke from rehab on 1/8/84 concurred with the diagnosis of cerebral death and the inappropriateness of any efforts of rehabilitation." Exhibit 25

Consequently, the evidence is absolutely clear that the child was clinically brain dead for as long as he lived. He never revived from his coma. Thus, under the rule set forth in the Final Decision in Case File 84-11, the disability of the beneficiary in question existed until he died and, as such, is prolonged within the meaning of the CHAMPUS regulation.

I find, then, that the medical care of the beneficiary, although it may have been appropriate hospitalization, was also custodial care. The reason for my finding is that the care as heretofore described met all the criteria for custodial care as set forth in DoD 6010.8-R, chapter IV.E.12.e.

CUSTODIAL CARE - ANOTHER CONDITION OR ACUTE EXACERBATION OF CONDITION

Even if the beneficiary is receiving custodial care, he may also receive CHAMPUS cost-sharing benefits for: (1) presence of another condition and (2) acute exacerbation of the condition for which custodial care is being received. DoD 6010.8-R, chapter IV.E.12.d.1. and 2.

In the case in question, the provider contends that even if the beneficiary was receiving custodial care, he also received care for complications related to his cerebral injuries. These complications, which included hypotension, anemia, respiratory and blood infections, pheumontis and diabetes insipidus, with resulting complications from his severe fluid loss, constitute either the presence of another condition or the acute exacerbation of the initial condition. (See Exhibits 23, 24 and 25)

First of all, there is no question that had not the child been injured initially, the medical complications would not have occurred. (See testimony of Dr. John Curtis) As such, I find that the complications were not another condition within the meaning of DoD 6010.8-R, chapter IV, E.12.d.1. Had the child received an injury or disability other than the one that he initially incurred, rather

that just a complication of that initial injury, my finding may have been different.

Secondly, concerning the contention that the beneficiary's complications of his initial injuries constitute acute exacerbation of those injuries, the record is clear that the beneficiary did have complications from his initial head injuries. The record is also clear, however, that had the child not been clinically brain damaged, these complications would not have occurred and that these complications also were generally anticipated from a patient who is clinically brain dead.

Dr. Curtis testified and Dr. Harper wrote (Ex. 5, p. 3 of 3) that once the child became clinically brain dead, they anticipated that he would die of pulmonary complications. Furthermore, there was never any change in the beneficiary's neurological status, the problem for which he received custodial care.

Finally, the provider also contends that the complications were treated by active medical attention from his treating physician and were treated necessarily in a hospital. While this may be true, the conditions were as a direct result of the patient's initial cerebral injuries and were anticipated by the treating physician once he was declared clinically brain dead. As such, this contention also cannot be used to justify coming within the acute exacerbation exception of the CHAMPUS regulation for custodial care.

As such, I find that the anticipated complications of one who is brain dead, whenever treated, do not constitute an acute exacerbation of the initial neurological condition of the beneficiary.

SUMMARY

In summary, it is the Recommended Decision of the Hearing Officer that the claims of the provider for inpatient hospital care of the beneficiary from Sepember 21, 1983, through January 12, 1984, be denied CHAMPUS cost-sharing benefits. The reason for the decision is that the care of the beneficiary was custodial care as defined by the CHAMPUS regulatons and law and is therefore excluded from CHAMPUS cost-sharing benefits. Furthermore, an additional reason for the decision is that the care received for this period of time also was not compensa-tory as being another condition or an acute exacerbation of the initial custodial care condition as defined by the CHAMPUS regulation and by law.

C. D. Heidgerd
CHAMPUS Hearing Officer

CHAMPUS claims for the episode of care in question. Issuance of this FINAL DECISION completes the administrative appeal process as provided under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

John Beary

John F. Beary, III, M.D.
Acting Assistant Secretary