DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

AURORA, COLORADO 80045-6900

SEP 15 1985

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of	)	
	)	
Sponsor:	)	OASD(HA) Case File 85-13
	)	FINAL DECISION
SSN:	)	

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 85-13 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary, the 29-year-old stepdaughter of a retired officer of the United States Navy, as represented by her stepfather. The appeal involves the denial of CHAMPUS cost-sharing for inpatient psychiatric care and professional psychotherapy services provided May 31 through December 20, 1981, at Brentwood Hospital, Shreveport, Louisiana. The amount in dispute is approximately $35,000.00.

The hearing file of record, the Hearing Officer's Recommended Decision, the oral hearing testimony, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. The Hearing Officer's recommendation is to deny CHAMPUS cost-sharing of the inpatient psychiatric hospitalization and professional psychotherapy services provided May 31 through December 20, 1981. The Hearing Officer found the inpatient care was experimental/investigational treatment, was not medically necessary, and was not provided at the appropriate level of care. In addition, the Hearing Officer found that psychotherapy in excess of five sessions per week was not necessary for crisis intervention.

The Director, OCHAMPUS, concurs with the Recommended Decision and recommends its adoption by the Assistant Secretary of Defense (Health Affairs) as the FINAL DECISION with additional discussion of the beneficiary's eligibility.

The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, adopts and incorporates by reference the Hearing Officer's Recommended Decision to deny CHAMPUS cost-sharing of the entire episode of inpatient psychiatric care, including professional psychiatric services, from May 31 through December 20, 1981. As recommended by the Director, OCHAMPUS, however, the Hearing Officer's Recommended

Decision is modified by additional discussion and finding regarding the patient's ineligibility for CHAMPUS benefits. This FINAL DECISION is based on findings the inpatient care constitutes excluded experimental/investigational treatment and was not medically necessary nor provided at the appropriate level of care. Although all professional psychiatric services related to the medically unnecessary and inappropriate inpatient care are excluded from CHAMPUS coverage, I specifically find that psychotherapy sessions in excess of five sessions per week were unnecessary for crisis intervention and would have been excluded from coverage even if any period of the inpatient care had been found to be CHAMPUS covered. I additionally find, as discussed below, that the patient was not eligible for CHAMPUS benefits subsequent to the termination of her marriage at age 24, which includes the period in issue in this appeal and, therefore, deny CHAMPUS cost-sharing of all care in dispute based on her ineligibility.

In my review, I find the Hearing Officer's Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence in this appeal. The findings are fully supported by the Recommended Decision and the appeal record. Additional factual and regulation analyses are not required except for the issue of the patient's ineligibility for CHAMPUS. The Recommended Decision is acceptable for adoption as the FINAL DECISION by this office as modified below.

Reparenting Therapy

As stated above, I have adopted the Hearing Officer's Recommended Decision that the inpatient psychiatric care constituted experimental/investigational treatment and is excluded from CHAMPUS coverage. The inpatient care in issue, reparenting therapy, was described by the attending physician as a program utilizing both a male therapist who functions as therapist and father figure and a female therapist who also functions as a therapist and a mother figure. Individual therapy by both therapists and group therapy in the hospital and office are provided. The office group therapy allows regression of the patient to work through early traumatic issues with corrective experiences from a therapy mom and dad. Published articles on reparenting therapy submitted for the appeal record further describe reparenting therapy; however, as noted by the Hearing Officer, the reparenting therapy provided to this beneficiary does not appear to come within the program discussed in the articles of record in this hearing. As noted by the medical reviewers, the lack of documentation detailing the actual care provided in this case makes a comparison extremely difficult. Regardless, the Hearing Officer found no support in these articles that reparenting therapy of any kind has been accepted in the medical community in the United States. The Hearing Officer correctly applied the standard of review of procedures/treatments questioned as experimental/investigational as adopted by this office in prior FINAL DECISIONS. The Hearing Officer found that in absence of documentation that any

nationally recognized professional organization has endorsed "reparenting therapy" as a generally accepted medical practice, he must find the treatment was experimental/investigational and not a CHAMPUS benefit. I agree and find "reparenting therapy" is an excluded experimental/investigational treatment regimen under CHAMPUS.

Eligibility

At the Formal Review appeal level, OCHAMPUS questioned the appealing party's eligibility for CHAMPUS at the time of receipt of care in dispute. The eligibility issue centers on the statutory language of 10 U.S.C. 1072 which defines "dependent" of a Uniformed Service member or former member to include an unmarried child (including an adopted child or stepchild) who either --

> "(i) has not passed his twenty-first birthday;
>
> "(ii) is incapable of self-support because of a mental or physical incapacity that existed before that birthday and is, or was at the time of the member's or former member's death, in fact, dependent on him for over one-half of his support; or
>
> "(iii) has not passed his twenty-third birthday, is enrolled in a full-time course of study in an institution of higher learning approved by the administering Secretary and is, or was at the time of the member's or former member's death, in fact dependent on him for over one-half of his support;
>
> ". . ." (10 U.S.C. 1072(2)D)

The appealing party, then, must meet this definition of "dependent" in order to be eligible for CHAMPUS benefits under 10 U.S.C. 1079 or 1086.

In reviewing the appeal file, OCHAMPUS discovered that the appealing party, date of birth November 18, 1951, had been married although the date of marriage is not indicated in the appeal file. OCHAMPUS did obtain a copy of the divorce decree which established a date of divorce of December 2, 1975, when the appealing party was 24 years of age. The appeal file also indicated occasional employment as a nurse. In view of these facts, OCHAMPUS was correct in questioning the patient's eligibility for CHAMPUS benefits. OCHAMPUS advised the appealing party of the concerns regarding eligibility.

The patient's representative provided a 1976 letter from the Department of the Navy, Bureau of Navy Personnel, advising that the Chief of Naval Personnel had determined that the appealing

party had a physical disability prior to her 21st birthday and was incapable of self-support and that her former marriage did not irrevocably disqualify her from dependency status. Therefore, an identification and privilege card was authorized.

Upon receipt of this information, OCHAMPUS requested the Department of the Navy to review the appealing party's eligibility. The Department of the Navy responded that, as an identification card had been issued, they [Navy] had no alternative but to honor her eligibility through November 1983 but would forward documentation for review by the Naval Medical Command. This response is legally incorrect. Erroneous issuance of an identification card in violation of Federal law does not estop the Government from denying benefits (Sellers v. United States, 3 Cl.Ct. 551 (1983)).

The Director, OCHAMPUS, has informed me that a recent check of the Defense Eligibility Enrollment Reporting System (DEERS) reveals the patient's eligibility was terminated as of October 10, 1981. The appeal file does not reflect if this decision and the rationale were provided to OCHAMPUS. Based on the DEERS information, however, the appealing party was not eligible for cost-sharing of the hospitalization in issue at least from October 10 through December 20, 1981.

The CHAMPUS regulation, DoD 6010.8-R, chapter III, implements 10 U.S.C. 1072 as concerns CHAMPUS eligibility and addresses the marriage of a child as follows:

> "Marriage of Child. A child of an active duty member or retiree who marries a person whose dependents are not eligible for CHAMPUS, loses eligibility, as of 12:01 a.m. on the day following the day of the marriage. However, should the marriage be terminated, by death, divorce or annulment before the child is twenty-one (21) years of age, the child again becomes a CHAMPUS eligible dependent (as of 12:01 a.m. of the day following the day of the occurrence which terminates the marriage) and continues up to age twenty-one (21) if the child does not remarry before that time. If the marriage terminates after the child's twenty-first (21st) birthday there is no reinstatement of CHAMPUS eligibility unless based on other entitlement." (DoD 6010.8-R, chapter III, E.3.d.)

In its 1976 letter, the Department of the Navy found the appealing party was disabled prior to age 21 and was incapable of self-support and her former marriage did not irrevocably disqualify her for CHAMPUS. As discussed below, this determination of eligibility was erroneous and is hereby revoked. The appealing party became ineligible for CHAMPUS upon the date

of her marriage. The above quoted statute and implementing regulation clearly provide that a child loses CHAMPUS eligibility upon his/her marriage and eligibility cannot be reinstated if the marriage is terminated by divorce after age 21. The evidence in this appeal establishes the beneficiary was divorced after age 21. Apparently, the Department of the Navy interpreted the phrase "unless based on other entitlement" in chapter III, E.3.d., above, as allowing a retroactive eligibility determination based on physical disability and incapacity for self-support, thereby providing for continuous CHAMPUS coverage as though the marriage and divorce did not exist. I find this an erroneous interpretation of Chapter III, E.3.d. The phrase "based on other entitlement" means eligibility can be reestablished only if the child remarries a person whose dependents are eligible for CHAMPUS (i.e., active duty or retired Uniformed Service member) as indicated in the first sentence of this provision. This interpretation is consistent with a similar Regulation provision (DoD 6010.8-R, chapter III, E.3.e.) which denies reinstatement of eligibility of remarried widows or widowers whose remarriage is terminated by divorce. However, to avoid this issue in the future, I am directing the Director, OCHAMPUS, to prepare a regulation amendment to delete the superfluous phrase "based on other entitlement."

The marriage issue aside, I further find that the patient failed to qualify as a "dependent" even under the criteria for incapacity. As noted above, the appeal file indicates the appealing party was occasionally employed as a nurse during and prior to the period in issue in the appeal. In order to qualify as an incapacitated dependent, the CHAMPUS regulation requires the incapacity to be continuous and, if the incapacity significantly improves or ceases after age 21, CHAMPUS eligibility cannot be reinstated on the basis of the incapacity. (DoD 6010.8-R, chapter III, B.2.c.(3)) In view of her employment as a nurse, a responsible position, the appealing party's continuous incapacity is not established and improvement is obvious. The Department of the Navy finding that her condition met the requirements for eligibility under the above cited provision also was erroneous.

Based on the above facts and regulation provisions, I find the appealing party was not eligible for CHAMPUS benefits subsequent to her marriage, and was not eligible as an incapacitated dependent because her incapacity was not continuous after age 21. Therefore, the appealing party was ineligible for CHAMPUS cost-sharing of the care provided May 31 through December 20, 1981.

SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the inpatient psychiatric hospitalization and professional psychotherapy services provided the appealing party May 31 through December 20, 1981, at Brentwood Hospital, Shreveport,

Louisiana. This FINAL DECISION is based on findings the inpatient care was experimental/investigational treatment, was not medically necessary, and was not provided at the appropriate level of care. Because the inpatient care was not medically necessary and was above the appropriate level, all professional services (including psychotherapy) related to the inpatient stay is excluded from CHAMPUS coverage. Had the professional services not otherwise been excluded from coverage, I find that psychotherapy in excess of five sessions per week would have been excluded under CHAMPUS in the absence of documented crisis intervention in the appeal case. I also find the appealing party was ineligible for CHAMPUS benefits subsequent to the date of her marriage or her employment as a nurse, which included the period in issue in this appeal. The date of ineligibility cannot be otherwise established as the appeal does not reflect the date of the marriage or initial employment after age 21.

The appeal and the claims of the appealing party are, therefore, denied. As this FINAL DECISION finds claims for inpatient care and professional psychotherapy services were erroneously cost-shared, the matter of potential recoupment of these funds is referred to the Director, OCHAMPUS, for consideration under the Federal Claims Collection Act. As the appealing party has been ineligible for CHAMPUS since her marriage, the matter of recoupment of CHAMPUS payments subsequent to her marriage is also referred to the Director, OCHAMPUS. Issuance of this FINAL DECISION completes the administrative appeal process under DoD 6010.8-R, chapter X, and no further appeal is available.

for William Mayer, M.D.

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

(Name of Beneficiary)

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

This case is before the undersigned Hearing Officer, pursuant to the Beneficiary's request for Hearing on the OCHAMPUS Formal Review Decision dated February 8, 1984. The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) has granted the Beneficiary's request for a Hearing. The Hearing was held in the Naval Hospital, Conference Room, Pensacola, Florida at 9:00 A.M. on November 21, 1984, pursuant to regulation DoD 6010.8-R, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Chapter X, "APPEAL AND HEARING PROCEDURES". At the Hearing, the Beneficiary was not present in person but was represented by CDR , USN, Ret, who is also her sponsor. Her mother was also present and OCHAMPUS was represented by Gary Fahlstedt, Attorney/Advisor.

This is the Recommended Decision of CHAMPUS Hearing Officer, Edward S. Finkelstein, in the CHAMPUS appeal case file and is authorized pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, Chapter X. The appealing party is , represented by , USN, Ret.

This appeal is based on the denial of CHAMPUS to cost-share inpatient psychotherapy sessions in excess of the regulated maximum amount of five sessions in a seven-day period. The fiscal intermediary initially denied coverage for the additional inpatient psychotherapy and this was upheld in a Formal Review Decison issued by OCHAMPUS on February 8, 1984.

The Hearing file of record has been reviewed. It is the OCHAMPUS position, dated November 7, 1984, that not only should the extension of CHAMPUS coverage for the inpatient psychotherapy be denied, but that CHAMPUS cost-sharing for the entire episode of care be denied therefore making the amount in dispute $35,085.92.

FACTUAL BACKGROUND

The Beneficiary, born November 18, 1951, was 29 years old when she was admitted to Brentwood Hospital in Shreveport, Louisiana on May 31, 1981 for reparenting therapy. The Beneficiary is the stepdaughter of a retired commander from the U. S. Navy.

Prior to the hospitalization in question, the Beneficiary had been experiencing psychological problems since the age of 15 or 16 according to the testimony at the Hearing. At the Hearing introduced Exhibit 42 which contained several medical reports on the Beneficiary dating back to December 1, 1971, which discussed psychiatric treatment of the Beneficiary even prior to that time. The situation that led to the hospitalization at Brentwood Hospital on May 31, 1981 began with a hospitalization in the Mental Health Unit of Human Hospital of Fort Walton Beach, Florida from May 18, 1981 through May 31, 1981. (Ex. 42) The reason for hospitalization at Fort Walton Beach is set forth in a report by , M.D., the Beneficiary's treating psychiatrist at that institution, as follows:

> "At the time of admission was a 30-year-old divorced white female who was admitted for severe depression and anxiety, and was in an acutely suicidal state. I had seen Ms. on an outpatient psychiatric basis, twice per week, since December 6, 1980 for treatment of personality borderline disorder and chronic anxiety and depression. Her medications included Artane Sequels 5 mg. q a.m. and hs, Ludiomil 25 mg. hs and Loxitane 10 to 25 mg. hs. On the day prior to admission she called me and related that she had a gun in her hand and had planned to shoot herself. Immediate admission was advised because of the patient's feelings of helplessness and hopelessness. Also, in the past she had taken large overdoses of medication requiring intensive care unit treatment. She was considered a severe suicidal risk at the time of her admission." (Ex. 42)

The reason for the Beneficiary's hospitalization at Brentwood Hospital on May 31, 1981 is set forth in the discharge summary submitted as Exhibit 47 as follows:

"REASON FOR HOSPITALIZATION: Twenty-eight year old nurse was transferred from a psychiatric hospital in Fort Walton Beach, Florida, to this facility for intensive long-term therapy. During the last ten years, she had been hospitalized on numerous occasions and has frequently presented to herself depressed, suicidal, and confused in her thinking. She had attempted a suicidal attempt which forced her admission into the hospital in Fort Walton. She remained depressed and suicidal and transfer was necessary for her own self-protection as well as proper treatment."

In the progress notes of the Beneficiary for the day of the initial hospitalization in Brentwood Hospital on June 1, 1981, Dr. Ware writes:

"This 28 yr. old female transferred from Ft. Walton Florida for intensive reparenting therapy. She has long psychiatric history with numerous hospital admissions. She demonstrates classical features of a borderline personality disorder." (Ex. 48)

The nurses record for the patient's first day at Brentwood Hospital on May 31, 1981 is also descriptive of the Beneficiary's status at that time:

"28 yr. old white female admitted ambulatory to 1st. floor accompanied by Ms. , R.N. & her parents. Assigned rm. 109-01. According to the ... pt. she has come to Brentwood to take part in Dr. 's program. Hoping to overcome her 'borderline problem.' Has no problem sleeping. Likes to work on stain glass for a hobby. Pt. stated the meds she was on & needed to continue on. Stated she has been bothered with sinus & a cold lately. Also some nausea & diarrhea. Call put into Dr. on call. Ph orders from Dr. to be noted. The pt's Mother says that her daughter has been a responsible nurse. Worked in special cardiac care. That she does not like to be talked down to. That she responds nicely to average tone of voice, but does not handle loud tones as easily. That her daughter is an only

child & is very intelligent. Is highly motivated. Plans on being here one year if necessary to overcome her problem. Fmly. are to have conference with Dr. . Trying to reach him so they might do that & head back to Fla. no later than noon tomorrow. Husband has to teach. Pt. having clothing etc. brought in by aide. Fmly. remains with her. To cafe for supper with her parents. Pt. & her parents in lounge at this time watching t.v. Parents left, pt. tolerated this well. Pt. met her rm. mate, later visited with her in their rm. Had punch to help celebrate pt's birthday. Walking about unit. No complaints. To cart for med. & later to bed." (Ex. 48)

The Hearing file contains a treatment plan for May 31, 1981 which does not mention anything about the patient's possible suicidal tendencies nor direct any safeguards to protect the patient from suicidal episodes. (Ex. 8, p. 4)

A history was performed on the Beneficiary by Dr. on June 13, 1981 and he noted the history of her present illness as follows:

"The patient states that for the past ten years she has been under treatment for a borderline schizophrenic personality. She states that for the past several months she has been doing quite well and was very interested in the reparenting program of Dr. 's. She states that this is the reason for her coming here. She denied any suicide, sleep, appetite or energy dysfunctions." (Ex. 8, p. 43)

On June 25, 1981, Dr. , the admitting physician, prepared a MENTAL STATUS REPORT on the Beneficiary which stated:

"Patient is a W-D/W-N, attractive, mildly obese young woman with dark hair and blue eyes. She appears slightly younger than her stated chronological age. She was alert, cooperative, and well-oriented. Patient had a high level of anxiety during much of the interview. She was expressing concern about being in the hospital and separate from Florida. She responded to support. There was no evidence of any significant depression. She

demonstrated excellent memory and recall. She could repeat six digits forward and five digits backwards. She subtracted serial sevens without difficulty. She could spell president and government and had good general judgment. She appeared to be of above-average intelligence.

"The patient talked openly about her difficulty and her repeated hospitalizations and mood changes. She has deep-seated fears of rejection and abandonment. She demonstrates rather classical features of a borderline personality with switches in regard to her transference of objects. She will escalate in feeling warm and safe to feeling angry and murderous. She will also escalate or move from feeling secure and adequate and functioning to a totally nonfunctional, helpless position. These frequent mood changes and shifts are precipitated by minimal stresses usually related to relationship difficulties. Motivation for regressive intensive reparenting therapy is excellent." (Ex. 8, p.44)

On June 13, 1981, just 13 days after her admission, the Beneficiary was permitted out of the hospital on a pass. The nurse's record indicates that the patient returned and said she had been shopping at the South Park Mall. (Ex. 48)

Upon a thorough review of the Hearing file by the Hearing Officer, the most detailed description of the conduct and progress of the Beneficiary is set forth in the nurse's record. (Ex. 48) An analysis of this record indicates that the Beneficiary had numerous passes to leave the hospital including some for purely personal reasons such as the one on June 13 to go shopping and another on June 18 to go shopping or on passes such as on July 10 to go with her reparenting mother, or to go to her group therapy at Dr. 's which was outside of the hospital. She also visited with friends outside of the hospital on passes such as on August 24 and went to a folk dance on August 29 outside of the hospital. On September 11 the Beneficiary went on a weekend pass with a female friend and did not return for two days until September 13, 1981. The Beneficiary then signed out on a pass on September 14, September 15 and September 16.

The nurse's record indicates that towards the end of September, 1981 the Beneficiary obtained employment at the P & S Hospital in Shreveport, Louisiana as an LPN. She would leave Brentwood with a work pass and travel by herself to her employment at the P & S Hospital. In early October 1981 the Beneficiary was informed by her employer that they wanted her to work in the

intensive care unit which she did for a short period of time, however, apparently some of her fellow employees at P & S Hospital found out that she was a pyschiatric patient at Brentwood Hospital and the Beneficiary felt that her fellow employees were speaking about her behind her back. This was on October 25, 1981.

There is mention in the nurse's record for October 14, 1981 that Dr. called around 6:00 P.M. aware that the Beneficiary felt suicidal at the time and she had requested an antidepressant but that the doctor was not issuing any order for same.

Some time around the end of October, 1981, the Beneficiary's former roommate at Brentwood committed suicide and this did greatly upset the Beneficiary. The nurse's record for October 30 indicates that she was upset and on October 31 that she was regressing. On November 2 the nurse's record indicates that the Beneficiary was expressing fear of returning suicidal tendencies because of her former roommate's death. On November 6, 1981, the nurse's record indicates that the Beneficiary went off the unit on a pass and returned to the unit indicating that she had enjoyed her pass and was talking to the staff about her pass. On December 2, 1981, the Beneficiary requested a transfer to the second floor at Brentwood Hospital and this was arranged for her. On December 5 she once again signed herself out on a pass to see some Christmas lighting and on December 18 she again signed out on a pass.

The progress notes for October 22, 1981 signed by Dr. indicate that the Beneficiary had been doing much thinking and was considering returning to Florida for treatment. Also in the progress notes of Dr. Ware dated December 14, 1981 he indicates:

> ". . . has made decision to be discharged on Sat & continue treatment at home. Part of this decision was made from anger about week-end." (Ex. 48)

No where in the progress notes nor in the nurse's record is there any substantial indication that the Beneficiary was indicating strong suicidal tendencies other than the previously mentioned entries of October 14 and November 2, 1981.

After the Beneficiary removed herself from Brentwood Hospital on December 20, 1981 OCHAMPUS did cost-share the entire period of hospital care, however, they did refuse to pay for more than five pyschotherapy sessions in a seven-day period and

, on behalf of the Beneficiary, appealed for a reconsideration.

The OCHAMPUS file was submitted to four peer reviewers in addition to Dr. , the Medical Director for OCHAMPUS who is also a pyschiatrist. One of the peer reviewers was on staff at Brentwood Hospital and therefore declined to review the file. Of the other three peer reviewers, Dr. Brandon refused to give an opinion because the records were inadequate and illegible. The Hearing Officer also found this situation to be the case and by virtue of Exhibit 38 requested legible copies of some of the medical records. These were later introduced as Exhibit 48.

Doctor 's Peer Review dated April 2, 1982 is relevant and is set forth as follows:

> "The patient is a twenty nine year old female, hospitalized from 5/31/81 through 12/20/81 for Reparenting Therapy. She has been in hospitals intermittently for the last ten years with borderline Schizophrenic Personality and has been depressed, suicidal and confused in her thinking. She has a history of allergy to Thorazine and Stelazine and received Loxitane and Ludiomil during her hospitalization. The dosage of Loxitane was 25mg. and the dosage of Ludiomil was 25mg.
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> "The progress notes are rather voluminous and many are not legible. Some were read, some were skimmed. The interim summaries indicate that the patient made over all progress with some fluctuations up and down in treatment goals. Her thinking judgment improved and she was able to function in a limited way outside of the hospital. Her regressions revolved around Symbiosis, feeling rejected and over reacting in stress situations. The daily notes seem to deal primarily with routine matters such as eating and sleeping. There was very little written by the primary treating physician. This is especially noteworthy since this type of Reparenting treatment is supposed to be very intensive. I think a detailed report of her progress and treatment as well as more history as to her previous hospitalizations and her personality function in (sic) needed to review the case adequately.
>
> "Some degree of medical care was necessary on admittance. She was described as suicidal. This

was not given in any great detail and it is difficult to evaluate on the basis of the information furnished. The appropriateness of the level of care is equally difficult to determine without a lot more information. It seems she received more than domiciliary care and certainly was in need of therapy. How much and the type of psychotherapy she actually received is unclear and we need this information, really, to determine more adequately the appropriateness of the level of care. Reparenting Therapy is, by definition, long term therapy and it would carry with it the need for the patient to become dependent and to regress. The choice of this treatment modality is more of a philosophical issue if it is an accepted type of therapy. It is difficult actually to tell if such Reparenting Therapy was adequately performed because of the limited information furnished us. To determine whether the length of hospital stay was appropriate we would need to have further information to assess. For example, we would need much more information on her previous treatments, what drugs were given, how she responded, length of hospital stays. The question of a physician signing a blank treatment plan sheet of course is an error and this should not have been done. I don't feel that the dosage of either the Loxitane or the Ludiomil is a sufficient quantity if she was as depressed and suicidal and confused as mentioned. Again, there are lots of notes in the record but these are not the type of notes that one can evaluate to determine a feeling for what treatment was going on and what progress was going on and the extent or the necessity for the therapy. I would have no reason to disapprove the claim. She did need therapy. She was receiving treatment. She did get better but I can not give an adequate review of the material." (Ex. 9)

After a request by the sponsor for reconsideration of the OCHAMPUS denial of coverage for the additional pyschotherapy sessions in excess of five one-hour sessions in a seven-day period, OCHAMPUS again submitted this file to another Peer Reviewer, Dr. Six questions were posed to Dr. Shepherd and he responded on January 3, 1983 as follows:

"Question 1. Did this patient's treatment or condition involve a crisis intervention situation.

"(a) No

"(b) By definition, a crisis is an acute situation. Most crisis situations involve outpatients. Whatever the results of a crisis intervention, the crisis is resolved in a short period of time or it becomes a long-term problem (and not a crisis).

"In an acute hospital setting, the potential for a crisis intervention decreases. Close watch, one-to-one observation, transfer to the intensive care unit, medication, and, if necessary, restraints can readily be utilized. If a patient is felt to be unable to take care of him/herself or represents a danger to him/herself or others, some of the above procedures would normally already be in effect.

"The patient's condition prior to admission is unclear.

"The Admission History indicates (06-13-81) that she 'had done quite well for the past several months and became interested in the reparenting program and was admitted for that reason'. This would seem to indicate an elective admission.

"Dr. indicates in his letter of 07-28-82 that she was transferred from another hospital but does not comment on her condition at the time.

"The Psychiatric Nursing History (05-31-81) shows her to be smiling, oriented, confident, attentive, to possess relevant speech, and to be without perception problems. The only problem described is that her thought progression although normal was circumstantial -- in itself a bit of a contradiction.

"In an interval Summary (08-27-81), which was unsigned, it is stated that she was depressed, suicidal, and confused at the previous hospital. However, the data indicates that these symptoms were not present at the time of admission.

"In the information available, consisting of Interval Summaries, Progress Notes, Nursing Notes, and Team Conference Summaries, I was unable to find

any evidence of situations requiring crisis intervention during her hospital stay. I must admit, however, that 50% of the Nursing Notes and some Progress Notes were unreadable.

"Question 2. If patient's case involved a crisis intervention situation, please state the number of psychotherapy sessions per seven day period which were necessary for this patient.

"Not applicable.

"Question 3. If this case involved a crisis intervention situation, please state the appropriate length of time for psychotherapy sessions in each 24 hour period which were necessary for this patient.

"Not applicable.

"Question 4. Did this patient require more than five psychotherapy sessions per seven day period as medically necessary treatment for patient's condition?

"(a) Based solely on the data available, my professional opinion would be a qualified no.

"(b) The nature of her condition and diagnosis are unclear. A diagnositic formulation is not present in this material.

"Dr. 's letter of 08-26-75 does give significant diagnostic information which would support a DSM III diagnosis of Schizophrenia, Residual Type, chronic (295.62) with a history of frequent acute exacerbations.

"Dr. 's letter on 07-28-82 gives no symptoms or diagnosis but does state, 'She then began intensive regressive psychotherapy for psychotics which we describe as reparenting'.

"The Admission History by Dr. gives no diagnosis. The brief history describes no symptoms from which one might derive a diagnosis. The Physical Examination gives no diagnosis either. It is unsigned.

"The Assessment Psychiatric Nursing History gives

no psychiatric diagnostic impression and, as I said above, indicates minimal psychopathology.

"The overall hospital record does not describe symptoms which, in my professional opinion, would tend to indicate more than a significant neurotic condition. The hospital record does state that she has the classic signs and symptoms of a borderline personality but there is no diagnostic formulation to support such a diagnosis or a specific statement of what they consider to be the classic signs and symptoms of a borderline personality.

"In view of this, the medical necessity of more than five times a week psychotherapy sessions is not supported.

"I qualified my answer because I felt that there might be a diagnostic formulation, psychological testing, and a staffing on the patient which would give clarification but which was not included in the data sent for review.

"Question 5. Considering this patient's condition, was the inpatient hospitalization from May 13, 1981 through December 20, 1981, the appropriate level required for medically necessary treatment. Please explain and state the length of time this hospitalization was the appropriate level of care.

"(a) No, not in its entirety and possibly not at all. Based on the data, I would only approve May 13, 1981 through November 4, 1981.

"(b) In my comments above, I have indicated that the hospital record indicates an elective admission with minimal symptoms described. Such an admission would require a great deal of data to meet the criteria of medical necessity. The only justification in the material presented for review was in Dr. 's letter of 07-28-82. It is contained in the following sentence: 'He and I agreed that intensive regressive psychotherapy was indicated and the only form of treatment which would be effective with this client.' Such a professional opinion would still require a great deal of supporting data. No such data was presented for review.

"If one felt the admission to be medically

necessary, there is then the question of length of stay.

"A Summary (10-20-81) states that the patient is working outside the hospital three days per week. In my professional opinion, at that point I would allow two weeks for discharge -- or November 4, 1981.

"In an Interim Summary (11-10-81) it is stated, 'Since that visit, she has decided to remain in the hospital until Xmas vacation'. Again, to me, this does not meet the criteria for medical necessity.

"Question 6. Considering this patient's condition, was the psychotherapy treatment from May 13, 1981 through December 20, 1981, appropriate medical care (that is, in keeping with the generally acceptable norm for medical practice in the United States)?

"(a) Based on the data presented for review, I have no idea.

"(b) I do not have sufficient information in these records, in my professional opinion, to make a diagnosis. The severity of symptomatology as presented in this material gives no clear indication of the patient's 'condition'. Without this data, I have no way to say what 'psychotherapy treatment' is indicated.

"Additionally, the hospital record presented for review does not clearly describe what the psychotherapy treatment was. Dr. 's brief statement of general treatment philosophy in his letter of 07-28-82 is not supported by the hospital records sent for review." (Ex. 25, p. 3)

, M.D. the Medical Director of OCHAMPUS rendered an opinion on the file recorded December 1, 1983 which indicated, in part:

"...the record is very vague in terms of defining the level of function or dysfunction of this individual.

"In general, she is a person who periodically

becomes psychotic, disorganized and unable to function outside of some kind of extenally (sic) and structured environment, whether that in fact is borderline personality disorder or a schizophrenic disorder, I do not think is quite as relevant in terms of our focus as the idea that we recognize that she is psychotic and needs treatment. So I want to at least say initially that what concerns me is that the diagnosis is not spelled out in a more systematic fashion which is consistent with the usual manner in which psychiatrists provide differential diagnoses in a kind of systematic process of ascertaining what the diagnosis is...We do not have an ascertaining of the diagnosis. On that basis then we cannot show much faith in the ascertainment of the Treatment Plan.

"This individual, basically, if she were either borderline or schizophrenic, certainly limited inpatient care periodically could be justified. The particular approach here though is, I think one that has concerned Dr. [redacted] and myself.

"A specific concern raised by you in this matter is whether reparenting therapy, whether for borderline or for schizophrenia, I do not think it really matters, is in keeping with the generally acceptable norm for medical practice in the United States.

"All I can say is that there have been a number of articles written in the psychiatric, psychological literature in the past 30 to 40 years which identify in a therapeutic relationship an attempt to provide a supportive, safe environment where the individual can be safely regressed, a kind of primitive dependence, a symbiotic kind of relationship can be developed between the therapist and the patient and then gradually with growing trust and the evolution of healthier, coping, adaptational kinds of behaviors that evolve from the treatment environment and from the individual psychotherapy, that the individual in effect learns to grow up.

"This is a theory that has been promulgated by a number of people and attempted in a number of instances over the past thirty to forty years. It is unproven to this date. There has never been any systematic, empirical evidence that either in an

analytically oriented, kind of regressive psychotherapy or specific kind of approach called reparenting as an expression of that kind of more general approach that that in itself is a treatment of choice or successful in treatment of either borderline personality or schizophrenia. It has been speculated and attempted for both conditions in a number of instances in the past. In some instances, some authors, medical researchers, physicians and psychologists have indicated that there has been success more or less with this kind of approach. Others have shown that there is no success...

"Reparenting therapy then is not proven, it is still investigational, and there has never been any significant embracement by the medical or psychiatric community that this is a treatment of choice or successful treatment for these conditions or for any other conditions. And, secondly, the specific prescription for this individual of this particular approach, I believe, is not justified by virtue of the fact that this individual had a number of symptoms and signs of her condition which would have indicated she was not likely to benefit from any kind of insight oriented, long term psychotherapy. Certainly for such individuals, the most successful kinds of treatments are oriented towards medications, group support, and other environmental therapies, such as vocational rehabilitation." (Ex. 32)

At the Hearing, the sponsor testified at great length about the Beneficiary's long history of mental illness including her involvement with the Hari Krishna movement and several hospitalizations and attempted suicides. The sponsor indicated that the suicide attempts were either an overdose of medication or, on one occasion, a starvation episode. He did indicate that she threatened to jump off of a ship while it was crossing the Atlantic and she also tried to jump out of a moving truck. Most recently the hospitalization at Ft. Walton Beach was precipitated, the sponsor indicated, by the Beneficiary holding a pistol to her head. The sponsor testified that emergency situations were occurring frequently and at least weekly while the Beneficiary was at Brentwood Hospital.

The Beneficiary's mother also testified to her daughter's long history of mental illness and substantiated the sponsor's testimony.

Unfortunately, Dr. , the Beneficiary's primary treating physician at Brentwood Hospital was unable to attend the Hearing held in this matter, however, he did submit a written report dated November 29, 1984. (Exhibit 46) Dr. Ware indicates in this report that his reparenting therapy is developed from his own background and experiences with other pyschiatrists and is not a nationally recognized course of treatment routinely used by other pyschiatrists. Dr. notes in his report that on several different occasions would become suicidal and self destructive and on other occasions she would become very angry and would require restraint. He goes on to state:

> "Most, if not all of her restraint, was done by me and her female co-therapist and most of her regressed angry work was done in group therapy. She on numerous occasions during this six to seven month period would become so confused in her thinking and so overwhelmed by her emotions that she clearly functioned at a psychotic level for several days at a time. It was absolutely impossible to have treated and maintained her during this period on an outpatient basis with these frequent and intense shifts of emotion and confusion in thinking. From my numerous experiences, I expected this type of behavior with her regression and this was the reason for the hospitalization and special program." (Ex. 46)

Dr. went on to indicate in his report that the Beneficiary was required and forced to participate in occupational therapy, recreational therapy, and all ward duties.

There is no documentation whatsoever in the files from any of the group therapy sessions.

As to whether or not Dr. 's reparenting therapy is nationally recognized, he states:

> "Reparenting therapy as I referred to it is not like reparenting therapy described in transactional analysis. There are some overlaps, but the type of regressive and total treatment that I have described is much more comprehensive. The type therapy I am describing is not included in the comprehensive textbook of psychiatry because it has

not been written up in detail." (Ex. 46)

There are several notations in the progress notes regarding the Beneficiary's involvement with the occupational therapy sessions as follows:

"7-17-81 Patient was contacted Friday, July 10, 1981 regarding new schedule in occupational therapy. Expressed some concern and anxiety about limited time in occupational therapy. However, patient has not attended occupational therapy this week, she did come to the department on Wednesday, July 15, 1981 but decided she felt tired and needed to rest. Plan to discuss non attendance with and if necessary provide more time as she requests it.

"8-7-81 Patient has not attended occupational therapy for the last 3 sessions. Occupational therapy staff has contacted her for each session, however she has given various reasons for non-attendance. Will continue to encourage occupational therapy participation.

"8-14-81 Patient attended occupational therapy on August 10 for an hour session.

"8-21-81 Patient has not attended occupational therapy since July 31st. She has been contacted several times weekly and each time has offered various reasons for not attending. Occupational therapy staff requests physician assistance in encouraging occupational participation.

"8-27-81 Patient attended occupational therapy on 8/21. She worked on an unstructured activity. She socialized well during the session and appeared to enjoy the clinic time. However she has not attended occupational therapy since then. Will continue to encourage occupational therapy participation.

"9-4-81 Patient continues to avoid attending occupational therapy for various reasons such as talking with volunteer worker on the hospital unit. On 9/2/81 she requested and was granted time in occupational therapy to iron clothes. This was not at a scheduled occupational therapy time. Will

continue to encourage occupational therapy participation at her scheduled time.

"9-11-81 Patient has not attended occupational therapy since 8/21/81, however she did come to the department to iron clothes on 9/2/81. Occupational therapy staff request physician's support in encouraging occupational therapy participation.

"9-25-81 Patient attended occupational therapy briefly on 9/25/81 and ironed some clothes. She has not actively participated in occupational therapy since 8/21/81. Plan to continue encouraging occupational therapy participation.

"11/13/81 Patient attended occupational therapy one time this week...Plan to continue encouraging patient to interact with peers and attend occupational therapy three times weekly.

"11/19/81 Patient attended occupational therapy only one time. She does not remain for the entire session.

"11/27/81 - 12/2/81 - 12/11/81 On these dates the progress notes indicate that the patient continued to attend occupational therapy daily.

"12/17/81 Patient has attended occupational therapy only one time this week."

As to the Beneficiary's involvement in recreational therapy, there only appears to be one entry under progress notes and that is on September 29, 1981 which states:

"Patient attends R.T. once a wk and do (sic) not spend more than five minutes." (Ex. 48)

The Hearing requested by the sponsor was held November 21, 1984 before OCHAMPUS Hearing Officer, [redacted]. The sponsor and his wife (parents of the Beneficiary) and [redacted], the OCHAMPUS Attorney/Advisor, were in attendance.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are: (1) Whether the reparenting therapy provided to the Beneficiary was experimental treatment or appropriate medical care, and (2) Whether the inpatient hospitalization in Brentwood Hospital provided to the Beneficiary from May 31, 1981 through December 20, 1981 was medically necessary and at the appropriate level of care, and (3) Whether the individual and/or group psychotherapy provided to the Beneficiary beyond five one-hour sessions per week from May 31, 1981 through December 20, 1981 were medically necessary or required for crisis intervention?

Two secondary issues will be addressed: (1) Whether OCHAMPUS is estopped from reviewing cost-sharing for the entire episode of care when an Appeal is filed to just a portion of a claim, and (2) What standards apply to maintenance of hospital records in CHAMPUS cases.

CHAMPUS benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in the Department of Defense Regulation 6010.8-R.

Chapter IV, subsection G.75., notes that the fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

Chapter IV, subsection G.1., states that service and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury are specifically excluded from the CHAMPUS Basic Program.

Chapter X, subsection A.3., of DoD 6010.8-R, specifies that, in all CHAMPUS appeal cases, the appealing party bears the burden of establishing entitlement to coverage for the disputed services and that such burden requires the presentation of "substantial evidence."

ISSUE: Whether the reparenting therapy was experimental treatment or appropriate medical care?

Chapter IV, subsection A.1., states that subject to any and all applicable definitions, conditions, limitations, and/or

exclusions specified or enumerated in the regulation, CHAMPUS will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury.

Chapter II, subsection B. 104., defines "medically necessary" in part, as the level of services and supplies (that is, frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury and states that "medically necessary" includes the concept of "appropriate medical care."

Chapter II, subsection B.14, defines "appropriate medical care," in part, as that medical care where the medical services 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 specifies that the medical environment in which the medical services are performed must be at the level adequate to provide the required medical care.

Chapter IV, subsection C.1., states that "Benefits may be extended for those covered services described in this section C of this Chapter IV which are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers. Such benefits are subject to any and all applicable definitions, conditions, exceptions, limitations and/or exclusions as may be otherwise set forth in this or other chapters of this Regulation."

Chapter II, subsection B.68., defines "experimental," in part, as medical care that is essentially investigatory or an unproven procedure or treatment regimen (usually performed under controlled medicolegal conditions) which does not meet the generally accepted standards of usual professional medical practice in the general medical community. Use of drugs and medicines not approved by the Food and Drug Administration for general use by humans (even though approved for testing on human beings) is also considered to be experimental. However, if a drug or medicine is listed in the U.S. Pharmacopeia and/or the National Formulary and requires a prescription, it is not considered experimental even if it is under investigation by the U.S. Food and Drug Administration as to its effectiveness.

Chapter IV, subsection G.15., excludes services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental procedures or treatment regimens.

Dr. 's report of November 29, 1984 indicates that the reparenting therapy that he practices such as that which was provided for the Beneficiary in this case is his own blend of his

training which he modified with techniques from his psychoanalytic training as well as other training which he refers to as reparenting. He indicates that this is a method of intense pyschotherapy for psychotics and borderlines. He indicates that the basic core for this therapy was from what he had learned from Dr. , Jr. with additions including the incorporation of a female therapist as well as a male therapist in treatment and the additional utilization of group therapy to provide intensive regressive experiences for the individual to work through old traumatic experiences and to have corrective experiences at an age regressed level which could be incorporated into their defective ego.

In determining the nature of the treatment provided to this Beneficiary, the medical opinion of the OCHAMPUS Medical Director, , M.D., who is a board certified psychiatrist, is of particular relevance. As stated by the OCHAMPUS Medical Director:

> "Reparenting therapy then is not proven, it is still investigational, and there has never been any significant embracement by the medical or psychiatric community that this is a treatment of choice or successful treatment for these conditions or for any other conditions. And, secondly, the specific prescription for this individual of this particular approach, I believe, is not justified by virtue of the fact that this individual had a number of symptoms and signs of her condition which would have indicated she was not likely to benefit from any kind of insight oriented, long term psychotherapy."

Dr. indicated that the type of therapy that he gave to the Beneficiary is not included in the Comprehensive Textbook of Psychiatry because it has not been written up in detail.

Dr. describes his Reparenting Therapy Program in one short paragraph of his letter of July 28, 1982 to OCHAMPUS (Ex. 16), as follows:

> "In this program each patient has a male therapist who functions as therapist and father figure and a female therapist who functions as therapist and mother figure. Each patient is seen individually several times weekly by both therapists and in group therapy daily in the hospital and twice in

the office. The office group is a specific group of people who are psychotic or borderline to allow them to regress and work through early traumatic issues as well as corrective experiences from a therapy Mom and Dad."

At the Hearing in this matter the OCHAMPUS Attorney/Advisor submitted Exhibits 44 and 45 which were published articles on reparenting. These articles support the OCHAMPUS position that reparenting therapy is not a generally accepted form of therapy. Neither of these articles cites any generally accepted method of reparenting therapy generally practiced within the medical community in the United States. In fact, one of the articles is written by four Argentinian practitioners. Even a review of these two reparenting articles indicates that the therapy, as practiced by Dr. on this Beneficiary, does not appear to come within the description of reparenting therapy as described in these two articles.

In Exhibit 44, the authors of the article indicate that they use three main types of reparenting techniques: (A) Birth and Growth (this begins with the rebirth of the child); and (B) Confrontation (which they indicate is only possible with the patient and their real parents either in family or group treatment); and (C) Self-Reparenting (where the patient is asked to create in their own minds the type of parents that they need). There is nothing in the record in this case to indicate that any of this type of reparenting therapy was used on the Beneficiary.

The self-reparenting article by , Ed. D. submitted as Exhibit 45 describes self-reparenting as a procedure for updating and restructuring the Parent ego state. She describes the process in self-reparenting whereby clients talk about their parents so that the therapist can understand or the patient themselves can understand influences that the parents made upon their egos. Unfortunately, there is virtually nothing in the record to describe the therapy given to the Beneficiary in the daily therapy sessions nor is there any detailed analysis of the Beneficiary's ongoing progress in these sessions but it does not appear that self-reparenting was used on this Beneficiary. The lack of documentation was also noted by the Peer Reviewers.

At the Hearing held in this matter, tne OCHAMPUS Attorney/Advisor, Gary requested that the sponsor have Dr. indicate in his report the acceptance of reparenting therapy in psychotherapy. In Exhibit 46 Dr. indicates how he developed and uses reparenting therapy but he does admit that, as stated above, it is not even included in the Comprehensive Textbook of Psychiatry. Apparently each practitioner has their

own version of what they feel reparenting therapy should be.

In Dr. 's Peer Review, he recognizes reparenting therapy as a type of therapy that is apparently practiced but does not indicate the general acceptance of it. Dr. goes on to indicate that he can't tell from the record if the reparenting therapy "was adequately performed because of the limited information furnished us." Dr. indicated that he needed much more information which was never supplied. He indicated that the actual type of therapy that was practiced on the Beneficiary is unclear. He further indicated that reparenting therapy is an intensive type of treatment and that the file just does not document an intensive course of treatment for the Beneficiary.

Dr. , another CHAMPUS Peer Reviewer was asked whether or not the psychotherapy treatment rendered during the Beneficiary's stay at Brentwood Hospital was in keeping with the generally acceptable norm for medical practice in the United States and he answered that "based on the data presented for review, I have no idea. I do not have sufficient information in these records, in my professional opinion, to make a diagnosis. The severity of symptomatology as presented in this material gives no clear indication of the patient's 'condition'. Without this data, I have no way to say what 'psychotherapy treatment' is indicated. Additionally, the hospital record presented for review does not clearly describe what the psychotherapy treatment was."

In view of the absence of documentation in the appeal file that any nationally recognized professional organization has endorsed "reparentng therapy" as a generally accepted medical practice in the treatment of a borderline personality disorder or schizophrenia requires that this Hearing Officer classify this treatment as experimental or investigational and therefore not a CHAMPUS basic benefit. (See Final Decision OASD (HA) 84-18) This is not to say that this therapy, as practiced by Dr. Ware, was not effective in the care and treatment of the Beneficiary but rather that it is not the type of care that is covered by the CHAMPUS Basic Program.

OCHAMPUS is faced many times with requests for payment of medical care and services rendered to a Beneficiary that are determined to be experimental or investigational. (See Final Decisions OASD (HA) 83-16, 83-17, 84-18, just to cite a few cases.) OCHAMPUS has even refused to pay for care that was investigational at the time the service was performed but which was an accepted medical practice at the time of the Hearing. (See Final Decision OASD (HA) 84-10) OCHAMPUS recognizes that physicians use procedures not generally accepted in the medical community. This is not criticized by OCHAMPUS as OCHAMPUS recognizes that this is the primary method of developing new

procedures and treatment in the medical community. (See Final Decision OASD (HA) 84-18) Nevertheless, by statute, the CHAMPUS Basic Program cannot pay for experimental or investigational treatment.

ISSUE: Whether the inpatient hospitalization in Brentwood Hospital provided to the Beneficiary from May 31, 1981 to December 20, 1981 was medically necessary and at the appropriate level of care?

Under DoD 6010.8-R Chapter IV, A.1., the CHAMPUS Basic Program may cost-share medically necessary services and supplies required in the diagnosis and treatment of illness or injury, subject to all applicable limitations and exclusions. Services which are not medically necessary are specifically excluded from coverage. (Chapter IV, G.1.)

Under Chapter II.B.104., "Medically Necessary" care is defined as that care which is adequate for the diagnosis and treatment of illness or injury and is further defined as including the concept of "Appropriate Medical Care." Appropriate Medical Care is then defined as medical care provided in keeping with the generally acceptable norm for medical practice in the United States. (Chapter II.B.14.a.)

Under the above cited provisions, in order for the care provided in this case to qualify for coverage as "Medically Necessary" within the meaning of the CHAMPUS regulation, it must be shown to be both "adequate" and "appropriate" for the treatment of the patient's condition. In other words, the treatment must be effecatious and in keeping with the generally acceptable norm for medical practice in the United States. In order to determine whether the care provided in this case was medically necessary and appropriate, the matter was referred to Peer Review for expert professional assessment.

As indicated in prior final decisions issued by the Assistant Secretary of Defense for Health Affairs, "the general medical community has endorsed Peer Review as the most adequate means of providing information and advice to third party payors concerning medical matters which may be in question." (Final Decision OASD (HA) 06-80)

In early 1982, this case was submitted to three Peer Reviewers--one of whom had a conflict and withdrew. Of the other two Peer Reviewers, Dr. [redacted] basically indicated that he was unable to review the case because the material submitted was inadequate and illegible. He felt there was just insufficient information about previous hospitalizations on which to base any assessment or understanding of the need for hospitalization and

the need for prolonged hospitalization.

The other Peer Reviewer, , M.D., also criticized the quality of the record but was able to formulate some opinions regarding the treatment. Dr. indicated that he did not feel the patient was on a high enough dosage of either Loxitane or Ludiomil if she was as depressed and suicidal and confused as the sponsor asserts. Dr. indicates that reparenting therapy is long term therapy and does require a patient to regress. From neither Dr. review of the record nor the Hearing Officer's review of the record are we able to focus on any documentation as to significant regression by the patient beyond some momentary episodes.

As a result of the request for reconsideration filed by the sponsor, OCHAMPUS submitted the case file once again to Peer Review and , M.D. by report dated January 3, 1982 (Hearing Examiner believes that the year was incorrectly typed and should have been 1983) evaluated this claim. When Dr. was asked by OCHAMPUS whether or not the Beneficiary's treatment was medically necessary he responded:

> "...I have indicated that the hospital record indicates an elective admission with minimal symptoms described. Such an admission would require a great deal of data to meet the criteria of medical necessity. The only justification in the material presented for review was in Dr. 's letter of July 28, 1982. It is contained in the following sentence: 'He and I agreed that intensive regressive pyschotherapy was indicated and the only form of treatment which would be effective with this client.' Such a professional opinion would still require a great deal of supporting data. No such data was presented for review."

Not only was no such data presented to Dr. for review but no such data has even been presented since Dr. Shepherd had an opportunity to review the appeal file. Dr. 's explanation for this lack of data is the statement in his letter of November 29, 1984 where he states:

> "I apologize for not making the intensity of her treatment clear during her hospital admission, but I never had a prior case challenged."

The Beneficiary's health during the period of time she was hospitalized was generally good. The appealing party has failed to meet his burden to show the Hearing Officer that there was a medical necessity to hospitalize the Beneficiary at Brentwood Hospital from May 31, 1981 to December 20, 1981.

It is abundently clear from the record that, other than the Beneficiary's psychiatric problems, there was no medical necessity to hospitalize her at all.

APPROPRIATE LEVEL OF CARE

Under DoD 6010.8-R, Chapter IV, B.1.g., the level of institutional care authorized under the CHAMPUS Basic Program is limited to the appropriate level required to provide medically necessary treatment. Services and supplies related to inpatient stays above the appropriate level required to provide necessary medical treatment are specifically excluded from CHAMPUS coverage by Chapter IV, G.3. Therefore, in order for benefit coverage to be extended for the care at issue in this case, it must be established that the inpatient hospital level of care was required and that the patient could not have been adequately treated and managed at a lower level of care.

As indicated above, the records submitted by Brentwood Hospital seem to indicate that the admission was elective as the Beneficiary was coming for the reparenting therapy, however, the report of Dr. , her treating physician at Ft. Walton Beach hospital indicated the severe suicidal tendencies of the Beneficiary. The Hearing Officer is somewhat perplexed by this extreme dichotomy. What sways the evidence in favor of the OCHAMPUS position is the virtual lack of documentation and nurses notes, progress notes, histories, etc. that would indicate that this Beneficiary was suicidal to the point where they had to take immediate precautions to protect the patient and otherwise look out for her best interests. In fact, just thirteen days after she was admitted, she was permitted to go out (apparently by herself) on a shopping trip to a mall.

This seems to clearly indicate that the admission to Brentwood Hospital was a voluntary elective admission. This admission is certainly not indicative of a level of dysfunction so severe as to require 24-hour a day acute inpatient hospitalization.

There is a clear dichotomy in the record between what the record shows as the reason for admission to Brentwood Hospital, i.e. to participate in Dr. 's reparenting program verses Dr. 's notes regarding the Beneficiary's

hospitalization at Ft. Walton Beach immediately prior to her transfer to Brentwood Hospital. Dr. , and the family at the Hearing, indicated that the Beneficiary had threatened suicide with a gun and was otherwise very suicidal, however, this just doesn't appear in the initial admission notes nor in the manner in which the Beneficiary was handled once she became a patient at Brentwood Hospital on May 31, 1981. The reason for hospitalization prepared by Dr. states in part "...transfer necessary for own self protection..." There is nothing in the record, however, to indicate that any special precautions were initiated to protect the Beneficiary. She was not immediately placed on strict observation nor placed under restraint or otherwise handled as a severe suicide threat.

Further evidence that 24-hour a day care was not required is presented by the fact that the patient had numerous and frequent passes throughout the period of hospitalization. The record is replete with evidence of passes for such purposes as shopping, going to a fair, going to a dance, going to a Christmas lighting and staying with friends. Even more illustrative of the fact that 24-hour a day acute inpatient hospitalization was not necessary is the fact that the Beneficiary worked as an LPN part-time for several weeks at another hospital in Shreveport, Louisiana while she was an inpatient at Brentwood Hospital. One night she even jogged from work at P & S Hospital to come back to Brentwood Hospital. There is quite a bit of evidence in the record that the nursing staff was supportive and assisted the Beneficiary but it is not documented that her condition was so severe that she had to remain as an inpatient in a 24-hour a day acute hospitalization situation. The Hearing Examiner is satisfied that it is not typical for pyschiatric inpatients to check themselves in and out with such unfettered liberty.

Dr. 's report of November 29, 1984 indicates his reasons for the inpatient level of care as follows:

> "Numerous crises occurred during this six to seven month hopitalization period. On several differenct occasions, would become suicidal and self-destructive and on other occasions, she would become very angry and would require restraint. Most, if not all of her restraint, was done by me and her female co-therapist and most of her regressed angry work was done in group therapy. She on numerous occasions during this six to seven month period would become so confused in her thinking and so overwhelmed by her emotions that she clearly functioned at a psychotic level for several days at a time. It was absolutely

impossible to have treated and maintained her during this period on an outpatient basis with these frequent and intense shifts of emotion and confusion in thinking. From my numerous experiences, I expected this type of behavior with her regression and this was the reason for the hospitalization and special program."

Again, Dr. paints a very strong picture for inpatient hospitalization but the hospital records do not back up his assertions. As already indicated, there are only two mild suicide situations that occurred during the hosptialization. At no time does the Beneficiary appear to be self destructive and there is no indication that she had to be placed under restraint on several occasions. Dr. does indicate that the restraint had to be done by he and the female co-therapist but, again, there is no documentation whatsoever in the file regarding any of work done by Dr. and the co-therapist. Also, there is nothing in the record to indicate that the Beneficiary was so confused in her thinking and so overwhelmed by her emotions that she functioned at a psychotic level for several days at a time. If this would have happened, the nurse's notes clearly would have indicated this type of situation--and the notes do not so indicate.

Dr. 's report of November 29, 1984 also indicates that the Beneficary participated in the total hospital inpatient program and milieu therapy and was required and forced to participate in occupational therapy, recreational therapy and all ward duties. He further indicates that she had to be physically forced to participate in these activities. Again, what Dr. indicates in his report is just not substantiated by the record. Earlier in this Recommended Decision, the Hearing Officer quoted the comments from the occupational therapist and at no time do they indicate that the Beneficiary was ever forced to participate in occupational therapy. To the contrary, the occupational therapist complained that the Beneficiary rarely participated in occupational therapy. Furthermore, there is virtually no documentation of recreational therapy for the Beneficiary and it is unclear what ward duties the Beneficiary had responsibility for. There is no documentation about this at all.

It should also be noted that on October 22, 1981, Dr. noted that the Beneficiary was thinking about and considering returning to Florida for treatment. Finally, the Beneficiary made her own decision to be discharged which was done in a fit of anger. The treating physician, Dr. , does not even seem to have tried to dissuade her from doing this in his notes of December 14, 1981. Clearly it seems that the Beneficiary was in charge of her inpatient status and not Dr. ! This, therefore was not an appropriate level of care for this Beneficiary.

ISSUE: Whether the individual and/or group psychotherapy provided to the Beneficiary beyond five one hour sessions per week from May 31, 1981 through December 20, 1981 were medically necessary or required for crisis intervention?

Chapter IV, paragraph C.3.i., provides the following:

"Psychiatric Procedures

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

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

Chapter IV, paragraph B.2.q., states that psychological evaluation tests are covered hospital services when required by the patient's diagnosis.

Chapter IV, paragraph C.3.f., states as follows:

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

"In the absence of such determination, benefits are payable only for inpatient medical care rendered by the attending physician."

In Dr. 's Peer Review, he indicated that he did not feel that the Beneficiary's treatment or condition involved a crisis intervention situation since that would call for an acute situation and he was unable to find from a review of the file that there was any evidence of situations requiring crisis intervention during her hospital stay. The Hearing Officer has also reviewed the file, and the testimony taken at the Hearing and is unable to find any proof of a crisis situation during the Beneficiary's course of treatment from May 31, 1981 through December 20, 1981.

Dr. 's report of November 29, 1984 indicates that numerous crises occurred during the hospitalization period and the family also testified to this, however, as indicated already in this Recommended Decision, there is absolutely no documentation of these crises as Dr. so well notes.

Even if it could somehow have been determined that the inpatient psychotherapy should have been cost-shared by the OCHAMPUS Basic Program, there clearly could not have been cost-sharing for more than five one-hour therapy sessions in a seven day period. This limit may only be exceeded for the purpose of crisis intervention. Although the limits were frequently exceeded in this case, the results of Peer Review and the review of the record by the Hearing Officer clearly indicate that the record is totally void of evidence of any situations of an acute and severe nature as to constitute a psychiatric crisis. Therefore, even if the inpatient care had been medically necessary and appropriate treatment provided at the appropriate level of care, benefits would not be available for pyschotherapy provided in excess of limitations established by Federal Regulation.

SECONDARY ISSUE: Estoppel

When an appeal is filed, the entire episode of care is addressed. In those incidences where there has been a previous cost-sharing of part of the claim, there is the possibility that previously paid claims will also be denied cost-sharing. The appeal process is not limited to segments of a claim; it must address the entire episode of care. (See Final Decisions OASD (HA) 84-10; 83-46).

The Hearing Officer is satisfied that the Beneficiary did improve from the time she entered Brentwood Hospital until the time she left, however the improvement was not based on treatment

and services that can be cost-shared by the CHAMPUS Basic Program as set forth herein.

SECONDARY ISSUE: Medical Records

Since a substantial basis for the denial of CHAMPUS Basic Program cost-sharing for the entire episode of care for this Beneficiary from May 31, 1981 through December 20, 1981 is based on the lack of adequate documentation in the medical records, the Hearing Officer refers the appealing party and the provider to the standard for psychiatric hospitals that has been developed by the CHAMPUS Program as set forth in Final Decision OASD (HA) 84-26, pages 3-10.

The position of the Hearing Officer as to the coverage for the inpatient pyschotherapy might have been different if the hospital records adequately described the nature and extent of the pyschotherapy that was given to the Beneficiary. No where in the record does this appear nor does it appear even in the last report of Dr. dated November 29, 1984. An analysis of the therapy actually given in the group therapy sessions might be considered an acceptable level of care even though it was called reparenting by Dr. but the hospital records submitted do not describe these therapy sessions at all. It had been pointed out to the sponsor several times by OCHAMPUS that the documentation was inadequate in this file yet no better documentation has been submitted.

The Hearing Officer did not make this a primary issue in this case as the issue as to whether or not the care rendered to the Beneficiary was experimental or investigational was a primary issue that could be considered without the full documentation normally required. That is the reason that the medical records are considered a secondary issue in this case.

SUMMARY

In summary, it is the recommended decision of the Hearing Officer that the entire episode of care of the Beneficiary at the Brentwood Hospital from May 31, 1981 through December 20, 1981 and all inpatient and outpatient psychiatric care rendered during that period of time be denied cost-sharing by the CHAMPUS Basic Program. This recommendation is based on the findings that:

1. The Beneficiary received reparenting therapy as described by her physician, Dr. , which was experimental treatment.

2. The inpatient hospitalization of the Beneficiary was not medically necessary and was above the appropriate level of care during the entire episode of care.

3. Individual and/or group psychotherapy in excess of five one-hour sessions per week from May 31, 1981 through December 20, 1981 were not medically necessary nor required for crisis intervention.

The Hearing Officer recommends that the entire episode of care from May 31, 1981 through December 20, 1981 be denied cost-sharing by the CHAMPUS Basic Program.

Edward S Finkelstein

Edward S. Finkelstein, Esquire
OCHAMPUS Hearing Officer

Dated: January 23, 1985