



ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

JAN 5 1984

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

Appeal of)
Sponsor:) OASD(HA) File 83-51
SSN:) FINAL DECISION

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 83-51 pursuant to 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is the beneficiary, a retired member of the United States Air Force. The appeal involves the question of CHAMPUS coverage of inpatient care for alcoholic rehabilitation provided the beneficiary from November 23, 1981, to December 28, 1981. The total hospital charge for the 35-day inpatient stay was \$11,218.60; the attending physician's fee for screening, psychiatric diagnostic interview, group therapy, and limited hospital services during the 35-day hospitalization was \$771.00. Although the CHAMPUS Fiscal Intermediary initially cost-shared both the hospital charge and attending physician's fee for the first 28 days of inpatient care, CHAMPUS coverage of care exceeding 21 days of hospitalization was denied upon review by OCHAMPUS as exceeding the regulation limitation on alcoholic rehabilitation programs.

The hearing file of record, the tape of oral testimony presented at the hearing, the Hearing Officer's Recommended Decision, and the Analysis and Recommendation of the Director, OCHAMPUS, have been reviewed. It is the Hearing Officer's recommendation that the denial of CHAMPUS cost-sharing for inpatient care and related medical services for treatment of alcoholism beyond 21 days (i.e., December 14, 1981, through December 28, 1981) be upheld on the basis that the hospitalization for this period was not medically necessary and was above the appropriate level of care. The Director, OCHAMPUS, agrees with the Hearing Officer's Recommended Decision and recommends its adoption as the FINAL DECISION. The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendations of the Hearing Officer and Director, OCHAMPUS, and adopts the recommendation of the Hearing Officer as the FINAL DECISION.

The FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is therefore to allow CHAMPUS cost-sharing of inpatient hospitalization at Boulder Memorial Hospital and related medical services of the attending physician from November 23, 1981, through December 13, 1981, but to deny CHAMPUS cost-sharing of inpatient hospitalization at Boulder Memorial Hospital and related medical services of the attending physician from December 14, 1981, to December 28, 1981. The decision to deny CHAMPUS cost-sharing of inpatient hospitalization and related medical services from December 14, 1981, to December 28, 1981, is based on findings the care provided was not medically necessary nor at the appropriate level of care and, therefore, exceeded the CHAMPUS coverage limits for alcoholic detoxification/stabilization and rehabilitation programs.

FACTUAL BACKGROUND

In November of 1981, the appealing party sought treatment for alcoholism at Fitzsimons Army Medical Center, Aurora, Colorado. A consultation report issued by the examining military physicians on November 16, 1981, indicated the beneficiary required inpatient alcoholic detoxification/rehabilitation which was not available at Fitzsimons Army Medical Center.

The 51-year-old beneficiary voluntarily admitted himself for treatment of his alcoholism at the Day-At-A-Time Unit, Boulder Memorial Hospital, Boulder, Colorado, on November 23, 1981. The history and physical examination conducted by W. D. Shiovitz, M.D., resulted in reported admission diagnoses as follows:

- "(1) Acute and chronic alcoholism.
- (2) Irritable bowel syndrome.
- (3) Myopia.
- (4) High frequency hearing loss.
- (5) Psoriasis.
- (6) History of tuberculosis exposure in the past.
- (7) History of bleeding ulcer [9 years earlier]."

Results of the physical examinations by Dr. Shiovitz were generally unremarkable. The beneficiary was reported as having no acute distress but exhibited mild erythema over his face and lesions comparable with psoriasis. In addition, the liver was detected as slightly enlarged. He exhibited symptoms comparable with irritable bowel syndrome with cramping and lower abdominal discomfort associated with diarrhea when he suffered stress. Regular medications included intermittent Valium and Mylicon for gastrointestinal problems.

The patient's history, as reported by Dr. Shiovitz, indicated that the beneficiary had been drinking alcohol since age 17 but had become a serious drinker over the past 3 years. Although he had no history of seizures, the patient admitted having some memory blackouts during periods of drinking. The patient did not

suffer from significant tremors although he had mild tremors on awakening in the morning.

On November 27, 1981, Dr. Mark Vary, a psychiatrist, conducted an admission psychiatric examination. This physician noted that the beneficiary described himself as a heavy, out-of-control drinker over the past 10 years and indicated that the drinking problem might have existed prior to that time period. Dr. Vary noted the patient had experienced blackouts and had found himself in the position of being unable to function well with his family or with employment because of his alcoholism. The patient's mental status as reported by Dr. Vary was as follows:

"The patient was oriented to time, place, person, and purpose. The patient's affect was appropriate throughout the session, although at times he became flooded with sadness and tears, especially when talking about his father and mother. Patient's manner during the interview was one of relatively slow talking, tension, holding style with fairly precise references to specific events and feelings. Underlying affect of depression appeared to dominate through many of the themes that the patient discussed. The patient's sensorium was clear, his recent and remote memory appeared intact. Patient's ability to calculate, abstract, apply judgment, and use insight all appeared within normal limits. There was no evidence of any thought disorder, hallucinations, or delusions."

The patient's diagnoses, as made by Dr. Vary and as incorporated into the hospital's inpatient admission record as the admitting diagnoses, were:

- "(1) Alcoholism, chronic and acute, habitual and excessive.
- (2) Depression and passive aggressive, passive dependent personality disorder.
- (3) Suspicion of family and marital dysfunction."

Dr. Vary noted that detoxification had been accomplished and made the following recommendation for a treatment plan and modality: "28 days of sobriety; education and exploration of the patient's use of alcohol and how alcoholism has affected his life; psychological testing to further delineate diagnostic impressions; psychosocial history and evaluation of the patient's wife and family, possibly including family in family treatment program; and, 28-day Day-At-A-Time (DAAT) Unit treatment."

The general treatment plan of the facility was as follows:

"First week: 1. To detoxify safely: to provide a supportive environment in which the patient can be 'socially' and/or 'medically' detoxified.

2. To initiate the assessment process: to acquire physical, psychological, and social data.

3. To facilitate the patient's interaction into the group and the program.

"Second week: 1. To continue psychosocial assessment.

2. To begin developing relationship capacities by effective utilization of the group process.

3. To develop self awareness as to the nature of dysfunctional behaviors.

"Third week: 1. To make more specific recommendations for discharge planning and integration into the community.

2. To evaluate further family dynamics and to intervene in any dysfunctional [sic] family systems.

"Fourth week: 1. To finalize discharge planning and to facilitate a smooth transition into the community.

2. To follow through on referrals.

3. To assist the patient with separation and closure."

The progress notes are uneventful and indicate that the beneficiary attended all of his meetings and therapy sessions, participated in those meetings, and was progressing. On December 10, 1981, the progress notes indicate the beneficiary was told he would be discharged at the end of the 28-day treatment plan if he continued to work at his present capacity, and if he made a breakthrough, he would be asked to stay longer. Dr. Vary's notes on December 11, 1981, indicate he agreed with the discharge date on the 28th day "unless patient requires extension due to successful work on feelings needing more time as an inpatient." On December 17, 1981, the counselor noted that the beneficiary would extend his inpatient stay for 1 week.

The progress notes indicate the patient had no serious medical difficulties and slept well from the beginning. The records indicate that the beneficiary was on pass from the hospital from December 13, 1981, until the morning of December 14, 1981. The beneficiary was also on overnight passes from the hospital on December 20 and 24, 1981.

The beneficiary was discharged from the hospital unit on December 28, 1981. The discharge diagnoses were alcoholism, chronic; depression with a history of psychophysiological gastrointestinal disorder in a man with a passive aggressive, passive dependent personality disorder; and marital and family dysfunction, somewhat resolved.

The hospital submitted a CHAMPUS claim for the 35-day inpatient alcoholic rehabilitation care in the amount of \$11,218.60. A CHAMPUS claim for the related medical services of the attending physician, Dr. Marshall Vary, in the amount of \$771.00 was also submitted to the CHAMPUS Fiscal Intermediary. The attending physician's claim included screening, psychological diagnostic interview, five psychotherapy sessions, five group psychotherapy sessions, and hospital visits.

The CHAMPUS Fiscal Intermediary for the State of Colorado, at that time Mutual of Omaha Insurance Company, submitted the claims to its medical reviewers for review of the medical necessity of the 35-day inpatient hospitalization. The review was conducted by three physicians and resulted in the following comments regarding the appropriateness of the 35-day length of stay. One physician responded, ". . . probably with alcohol + Valium + Depression. We have no progress notes or orders to document the complications or extra treatment described in the attending [physician's] letter. Probably o.k. to pay although ideally we would see M.D. progress notes and order."

The second physician responded, "Too long - I would approve 28 days." The third physician responded with, "The level of care and the therapeutic program are appropriate for the diagnosis. The information supplied by the provider is inadequate to justify extending the inpatient treatment beyond 21 days."

The CHAMPUS Fiscal Intermediary approved coverage of the first 28 days of the beneficiary's inpatient alcoholic rehabilitation program (i.e., November 23, 1981, through December 20, 1981) and denied coverage of the last 7 days of inpatient care. Of the \$11,218.60 hospital charge, the fiscal intermediary allowed \$9,908.10 and paid the 75% cost-share of \$7,431.07. Of the \$771.00 physician charge, the fiscal intermediary allowed \$660.07 and paid the 75% cost-share of \$495.60. The fiscal intermediary's case review log contains the following explanatory comments:

"Reviewers approved care as generally appropriate for cost-sharing, but disagreed over the justifiable length of stay. We'll cost-share 28 days as [rehabilitation], a compromise."

The partial denial of CHAMPUS coverage was appealed to the fiscal intermediary and copies of the physician's orders and progress notes were submitted for review. The case was again referred to the same three reviewing physicians by the fiscal intermediary

for medical review. The opinions of the three reviewers were that the additional information did not document any medical complications and did not document that the patient's depression was addressed in treatments.

Upon further appeal, the fiscal intermediary referred the case to three new reviewing physicians. One physician stated:

"I can see no reason for extending coverage of this care at all in this review. Patient was said to have depression but no evidence of any specific treatment of such. Psychological tests were to be given but there is no evidence that they were done and certainly not reported. This program was a fixed program of 28 days from 'day one' and was extended at request of patient as evident in note of 12/11/81 which was a 14 day review.

"I feel that the treatment in this case was excessive and would not agree in principle with the extension to 28 days. 21 days would have been adequate but since you have compromised to 28 days, I see no reason for 35 days."

A second physician stated:

"It appears clear to me that inpatient detoxification and rehabilitation for this man's alcoholism were both absolutely indicated. In addition, the detoxification and rehabilitation program as outlined in the accompanying record seems quite appropriate. Medically, a 35-day inpatient detoxification and rehabilitation does not seem excessive to me. However, there is no clear-cut medical indication presented in this record for an extension of the usual CHAMPUS benefits I might add, that for this reason it seems unclear to me as to why 28 days were approved originally when the standard reimbursement is for 21 days. I therefore find myself in a position of wanting to approve reimbursement for the treatment which I feel is appropriate, yet being unable to find any indication to go against standard reimbursement guidelines."

The third physician stated:

"In my opinion a program of 28 days is very adequate. Any underlying psychiatric

∴ problem - i.e., depression - could be addressed [outpatient]. I see no reason to extend coverage beyond the 28-day period."

In response to the appeals in this case, the CHAMPUS Fiscal Intermediary continued to deny CHAMPUS coverage of the beneficiary's inpatient alcoholic rehabilitation beyond 28 days. The case was then appealed to OCHAMPUS.

Included with the appeal to OCHAMPUS was additional information from Dr. Vary regarding the patient's prolonged inpatient care. According to Dr. Vary, the reason for extended inpatient care was, in part, ". . . a significant depression which was treated concomitantly with the patient's alcoholism. In addition, the patient was extended in treatment due to his difficulty in allowing more meaningful interpersonal relationships to develop."

The case file was referred to the American Psychiatric Association (APA) for medical review prior to issuance of an OCHAMPUS First Level Appeal Decision. In summary, the APA reviewer opined that the beneficiary, upon admission, did not display any signs to indicate that he was in an acute state of alcoholism. Although the physician's orders suggested the beneficiary required detoxification, there were no objective signs to indicate the necessity for detoxification. He further noted that there were no medical complications described in the record which would require hospitalization; hospitalization was not required for the consultation regarding pain in the patient's left shoulder or the patient's minimal gastrointestinal complaints. In the reviewer's opinion, the patient's depression was minimal and could have been treated in an outpatient setting after 21 days. Finally, this reviewing psychiatrist noted that the patient's presence in the hospital was helpful only because it assured that the beneficiary would abstain from alcohol and removed him from stressful situations. On November 5, 1982, the OCHAMPUS Medical Director, also a psychiatrist, reviewed the file and concurred with the responses of the APA reviewing physician.

Following the review, it was determined that the CHAMPUS Fiscal Intermediary had not properly applied the CHAMPUS guidelines on alcoholic rehabilitation in processing the beneficiary's claims. Under the CHAMPUS guidelines, coverage of inpatient alcoholic detoxification/stabilization and rehabilitation programs is limited to 21 days of care in the absence of medical complications requiring a longer period of inpatient care.

Based on the absence of documentation indicating medical complications, the OCHAMPUS First Level Appeal Decision determined that the beneficiary's inpatient hospital care was not medically necessary and was not at the appropriate level of care after December 13, 1981, the 21st day of care. Therefore, all hospital charges and related medical services from December 14, 1981, through December 28, 1981, were disallowed and the fiscal intermediary was instructed to take appropriate recoupment action to recover those funds erroneously paid by the

fiscal intermediary for care received by the beneficiary after December 13, 1981.

The beneficiary appealed and requested a hearing. In connection with that appeal, the beneficiary submitted a letter from the treating physician, Dr. Vary. This letter stated:

"Without question [the beneficiary] was suffering from a significant depression which, in my opinion, at that time, without an in-patient treatment, significantly placed your health, indeed life, at risk."

Dr. Vary further stated:

"As you may remember, as you approached discharge from the hospital, we recommended to you that you consider an extension. This was related to two specific issues that we felt were pertinent in your treatment. First, that you continued to evidence significant emotional lability with depression which would be demonstrated by your, at times, lapsing into states of profound hopelessness in relationship to difficulties you were encountering as you attempted to handle in a sober way, feelings and relationships as they developed in treatment. The other major issue which related to our recommending an extension was our concern that in your relationships with others on the unit, you consistently related to others in a condescending manner as if you were 'their superior.' It was our sincere concern that this style of relating would not serve you well in your attempts to establish relationships as a sober person through AA and otherwise, and had led in the past to significantly distant relationships which contributed to your alcoholism.

"The decision that we made to recommend an extension of your treatment to you was based on the coexistence of these two factors which we felt seriously threatened the fragile adaptation that you had made at that time to sobriety. It was the opinion of the staff and myself that you were at significant risk for a relapse and that you had expressed many times the sense of hopelessness which we were concerned might lead to a suicide attempt, had you been unable to recover from this relapse. Therefore, it was with these factors in mind that we recommended to you

that you decide to extend your treatment on an in-patient basis with us.

"In review of the chart, I can understand how the peer review came to decide that you needed only 21 days of treatment. Unfortunately, the chart and the notations in it reflect your progress in treatment much more accurately than the remaining and persistent clinical concerns which contributed to the recommendation of an extension.

"Although I referred, in my discharge summary, to the above factors that contributed to the extension, the extent of these problems was not fully documented in the progress notes and other places in your clinical record.

"I hope this letter explains to you as clearly as possible both the reasons for our recommendation of an extension and the necessity that we saw at that time that you remain in the hospital. In this matter our recommendation to you and your decision, I believe, was sound.

"Without question you were suffering from a significant depression which, in my opinion, at that time, without an in-patient treatment, significantly placed your health, indeed your life, at risk. It is my hope that this opinion is sufficient to enable your insurance carrier to assist you in covering this necessary treatment."

Prior to the hearing, the additional information was submitted to the Medical Director, OCHAMPUS, for review. It was the opinion of this psychiatrist that:

"The letter forwarded by the beneficiary, written by M. G. Vary, M.D., P.C., on 25 February 1983, indicates concerns about depressed mood and attitude that the provider thought at the time of treatment would interfere with post-discharge sobriety, relationships, and emotional health. Moreover, Dr. Vary acknowledges that the clinical record reflects no significant references to these issues except in the discharge summary, which indicates the hospitalization was 'prolonged due to a significant depression.' The APA peer reviewers have previously expressed concerns

about the lack of documentation about medical (psychological) conditions that might have existed and that could have allowed extension of care beyond 21 days with adequate evaluation, formulation and notation. [The Medical Director] can only underscore the concerns of the APA reviewers if a 'significant depression' existed, it was evidently not adequately evaluated, treated, or noted in the record. Moreover, contemporary standards of care in the U.S. would require that such serious concerns as raised by Dr. Vary in his treatment of the patient should have been documented. Such documentation would be required by both JCAH and OCHAMPUS. Therefore, lacking such documentation and notwithstanding Dr. Vary's additional information submitted, the inpatient care beyond 21 days is not medically necessary.

* * * *

"The record does not reflect that professional outpatient treatments (e.g., psychotherapy for the 'significant depression' and problems with relationships) was [sic] considered as an alternative to inpatient treatment."

A hearing was held in Aurora, Colorado, on May 31, 1983, before Hanna M. Warren, Hearing Officer. The beneficiary was present and testified at the hearing. The treating physician, rather than presenting testimony at the hearing, submitted a letter to the Hearing Officer for consideration. This letter stated:

"In [the beneficiary's] treatment for his alcoholism, a critical complication to the course of his treatment, namely a significant depression was noted from the time of his admission and throughout his hospital stay. This depression complicated his treatment in that [the beneficiary] was subject to very rapid and often unpredictable reactions of extreme sadness and remorse which would essentially overwhelm his ability to relate to others or to control himself.

"This type of emotional reaction, in my experience, is not typical of an alcoholic undergoing rehabilitation treatment who does not suffer from a co-existing psychiatric condition, namely, depression.

"As a secondary coping mechanism to this overwhelming sense of vulnerability [sic], hopelessness and loss that he experienced, [the beneficiary] would often assume an air of superiority in his relating to other people. This kept him less vulnerable [sic], distant, and relatively unaffected emotionally by these experiences. The combination of this underlying significant depression and the patient's defensive personality style to relating to other people, made him significantly at risk for relapse, if he had not continued in the inpatient program.

"To state this more clearly, the unpredictable and profound sense of depression, that [the beneficiary] experienced during his inpatient treatment would have, I believe with reasonable medical certainty, placed him in high risk for relapse with regards to his alcoholism. This was true at the patient's 28th day of treatment and would have been a higher risk at the patient's 21st day of treatment.

"Therefore, I can state unequivocally to you that in my opinion [the beneficiary's] hospital stay after the 21st day of treatment was due to the medical necessity for him to continue treatment for his depression, and that this medical necessity continued until his discharge from the hospital on the 28th of December, 1981.

"I am aware that psychiatrist peer-reviewers have reviewed the medical record and have stated an opinion different from this opinion. I acknowledge that the medical record did not in fact demonstrate this degree of impairment. However, it is my absolute and firm belief that this level of impairment existed and that [the beneficiary's] health would have been seriously endangered, if he would have left the hospital at either the 21st or 28th day of treatment."

At the hearing, the beneficiary testified concerning a previous outpatient effort to rid himself of alcoholism which proved unsuccessful. The beneficiary also testified that the treatment routine for the last 2 weeks of his inpatient rehabilitation care was the same as the first 2 weeks; i.e., he attended counseling, lectures, seminars, movies and tapes on the psychological and sociological aspects of alcoholism, and he participated in group

therapy and an exercise program. He stated that he felt the additional time was beneficial because he began to make progress. Previously he was displaying defense mechanisms which prevented his total rehabilitation.

The beneficiary also testified that after discharge from the hospital he returned for outpatient care in an organized program conducted by the treatment facility. As summarized by the Hearing Officer, the beneficiary testified that:

"He met in a group with some of the patients who had been there when he was in the hospital and also some of the new patients. At this time of transition, [the beneficiary] described his group meetings as helping them and helping himself. He went once a week in the evening for these group therapy sessions.

"During his hospitalization [the beneficiary] attended AA meetings almost every day at some location outside of the hospital, such as in Boulder, Longmont, or the Alcohol Recovery Center in Boulder. In addition, there were twice a week meetings in the hospital. After his discharge he went to the hospital to these AA meetings and also to outside AA meetings. He testified that the aftercare program was set up for 6 weeks but he attended for 10 to 12 weeks and he was the one to make the decision when it was time to quit. He had no contact with Dr. Vary during the aftercare program.

The Hearing Officer has submitted her Recommended Decision. All prior levels of administrative appeal have been exhausted and issuance of a FINAL DECISION is proper.

ISSUES AND FINDINGS OF FACT

The primary issues in this appeal are whether the inpatient hospitalization for treatment of alcoholism was medically necessary and at the appropriate level of care for the treatment of alcoholism.

Medically Necessary/Appropriate Level of Care

Under the CHAMPUS regulation, DoD 6010.8-R, chapter IV, A.1., the CHAMPUS Basic Program will 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 (chapter IV, G.1.). Under chapter II, B.104, "medically necessary" is defined as:

∴ ". . . the level of services and supplies (that is, frequency, extent and kinds) adequate for the diagnosis and treatment of illness or injury"

CHAMPUS coverage is subject to the requirement that medical care be provided at the appropriate level of care. The CHAMPUS regulation, chapter IV, B.1.g., provides, in part, that:

"Inpatient: Appropriate Level Required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment."

The general concepts of "medically necessary" and "appropriate level of care" are further defined in relation to the extent of CHAMPUS coverage of inpatient care for alcoholism by DoD 6010.8-R, chapter IV, E.4., as follows:

"4. Alcoholism. Inpatient hospital stays may be required for detoxification services during acute stages of alcoholism when the patient is suffering from delirium, confusion, trauma, unconsciousness and severe malnutrition, and is no longer able to function. During such acute periods of detoxification and physical stabilization (i.e., 'drying out') of the alcoholic patient, it is generally accepted that there can be a need for medical management of the patient, i.e., there is a probability that medical complications will occur during alcohol withdrawal, necessitating the constant availability of physicians and/or complex medical equipment found only in a hospital setting. Therefore, inpatient hospital care, during such acute periods and under such conditions, is considered reasonable and medically necessary for the treatment of the alcoholic patient and thus covered under CHAMPUS. Active medical treatment of the acute phase of alcoholic withdrawal and the stabilization period usually takes from three (3) to seven (7) days.

"a. Rehabilitative Phase. An inpatient stay for alcoholism (either in a hospital or through transfer to another type of authorized institution) may continue beyond the three (3) to seven (7) day period, moving into the rehabilitative program phase. Each

such case will be reviewed on its own merits to determine whether an inpatient setting continues to be required.

"EXAMPLE"

"If a continued inpatient rehabilitative stay primarily involves administration of antabuse therapy and the patient has no serious physical complications otherwise requiring an inpatient stay, the inpatient environment would not be considered necessary and therefore benefits could not be extended.

"b. Repeated Rehabilitative Stays: Limited to Three (3) Episodes. Even if a case is determined to be appropriately continued on an inpatient basis, repeated rehabilitative stays will be limited to three (3) episodes (lifetime maximum); and any further rehabilitative stays are not eligible for benefits.

However, inpatient stays for the acute stage of alcoholism requiring detoxification/stabilization will continue to be covered. When the inpatient hospital setting is medically required, a combined program of detoxification/stabilization and rehabilitation will normally not be approved for more than a maximum of three (3) weeks per episode.

"c. Outpatient Psychiatric Treatment Programs. Otherwise medically necessary covered services related to outpatient psychiatric treatment programs for alcoholism are covered and continue to be covered even though benefits are not available for further inpatient rehabilitative episodes, subject to the same psychotherapy review guidelines as other diagnoses."

In view of the above, CHAMPUS coverage of inpatient treatment of alcoholism consists of detoxification/stabilization and rehabilitation; however, coverage will not normally be approved for more than a maximum of 3 weeks per inpatient episode. As noted by the Hearing Officer, several previous decisions of the Assistant Secretary of Defense (Health Affairs) have interpreted the limitations on CHAMPUS coverage of inpatient alcoholic treatment programs.

In referencing the previous FINAL DECISIONS in OASD(HA) Case Files involving alcoholic treatment programs, the Hearing Officer stated:

∴ "Several previous decisions of the Assistant Secretary of Defense (Health Affairs) involved alcohol rehabilitation and applied the above regulatory provision. It was held that 'even in a case where the initial phase of inpatient rehabilitation stay for alcoholism qualifies for benefits, in order for such benefits to continue beyond 21 days there must be determination of a medical need for the stay to continue' (OASD(HA) 2-80). Another decision specifically stated: 'In order to extend CHAMPUS coverage for inpatient care beyond 21 days, the specified regulation norm, the hospitalization must be necessary for treatment of the medical complications associated with alcohol withdrawal' (OASD(HA) 80-04). The decision went on to conclude 'the exception to the normal 21 day limit is the existence of severe medical effects of alcohol, medically requiring an inpatient setting.' Without these conditions inpatient care beyond the normal period is an inappropriate level of care under the CHAMPUS Regulation."

The Hearing Officer has correctly summarized the CHAMPUS policy regarding inpatient alcoholic treatment programs applicable to the treatment program under appeal in this case. In applying this policy to the facts in this appeal, the Hearing Officer found no documented medical conditions requiring a continued inpatient stay beyond the normal 21-day period covered under CHAMPUS. In reviewing the record, the Hearing Officer stated:

"The record contains two letters from Dr. Vary regarding his medical concern for [the beneficiary's] need to remain in the hospital. Both state that [the beneficiary] exhibited a 'significant depression' and unpredictable feelings of extreme sadness and remorse. In addition, [the beneficiary] had a defensive personality style which kept him less vulnerable [sic] and more distant in his relations with other people. These made him a high risk for relapse, according to Dr. Vary, if he had not continued in the inpatient program. In his letter of February 25, 1983, Dr. Vary expressed concern regarding a potential suicide attempt because of [the beneficiary's] feelings of hopelessness.

"There appears to be little question that Dr. Vary and the other staff felt continued hospitalization was beneficial and [the

beneficiary] expressed this conviction at the hearing. This is not though the basis on which I must make my decision. The CHAMPUS regulation is specific that the normal period of benefit for alcoholism rehabilitation is 21 days. This becomes the appropriate level of care for CHAMPUS coverage unless there are unusual and continued medical needs and circumstances to extend this period. I have carefully examined the record and find there are no documented medical conditions requiring a continued inpatient stay beyond the normal 21 day period.

"Although in his letter Dr. Vary recalls a significant depression, there are no contemporaneous notes or records noting that concern, nor directing any specific treatment to that problem. No psychiatric evaluation appears to be suggested or conducted, nor was any medication given for depression.

". . . In the diagnostic impressions, the psychologist [sic] does state 'Depression and history of psychophysiological gastrointestinal disorder in any individual with a basically passive dependent passive aggressive disorder,' but no specific recommendations or concerns are expressed regarding the treatment of depression. I have carefully examined the progress notes made by the staff and the physician's orders and progress notes made by Dr. Vary and can find no specific treatment or directions for this condition. As early as November 28th, the progress notes show patient to be close to tears, but less 'overwhelmed' than before. There is no reference in the entire record to any concern regarding a suicide attempt except Dr. Vary's letter of February 25, 1983, nor is there any recommendation for continued outpatient treatment for the depression.

"The treatment program was set up for a normal 28 day period according to the record and [the beneficiary's] testimony. He was invited to stay beyond 28 days because of the progress he was making. The record would indicate that this decision to remain was made to a large extent by [the beneficiary]. The progress notes on December 11th state, 'Patient and staff and I are in agreement with above. Discharge will be on 28th day

unless patient requires extension due to successful work on feelings needing more time as inpatient.' On December 17th the notes read, 'He will extend for one more week. Discharge date 12/28. He would like another pass during this time.' No mention was made of any specific medical concerns regarding the discharge date. [The beneficiary] testified at the hearing he was elated at being given the opportunity to stay because it meant he was making progress.

"This claim has been reviewed by eleven peer reviewers and the medical director of OCHAMPUS. In their discussion of the medical record, none of them find evaluation, discussion or treatment of a specific depression in the last two weeks of [the beneficiary's] inpatient stay. The plan of treatment after the twenty-first day was found to be of a type that could be performed on an outpatient basis and it is my decision that the weight of the evidence supports this conclusion.

"[The beneficiary] testified that the important work, he felt, was done in and with the groups. After discharge he came back to meet with the group and attend AA meetings. There is no compelling medical reason shown by the record which would demonstrate that this outpatient treatment would not have been an appropriate level of care after the initial three week hospitalization. Although the record indicates [the beneficiary] did have an initial resistance to treatment which took some time to overcome, possibly most of the first three weeks, the plan of treatment conducted after this period does not appear from the record to require retention in an acute hospital setting and is of the type that could have been adequately performed on an outpatient basis."

I agree with the Hearing Officer and adopt her findings that inpatient care beyond December 13, 1981, was not medically necessary, could have been performed on an outpatient basis, and, therefore, exceeded the CHAMPUS normal limits of 21 days of coverage of inpatient alcoholic treatment programs.

Services Related to Non-Covered Hospitalization

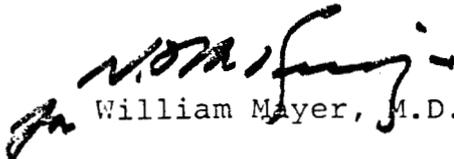
Under the provisions of DoD 6010.8-R, chapter IV, G.3., CHAMPUS specifically excludes from coverage:

"Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care."

Having determined that the beneficiary's last 14 days of hospitalization were not medically necessary and were above the appropriate level of care, all services and supplies, including physician care, related to that period of hospitalization are also excluded from CHAMPUS coverage.

SUMMARY

In summary, it is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) that the inpatient care from November 23, 1981, through December 13, 1981, was medically necessary and meets the CHAMPUS criteria for coverage of inpatient treatment of alcoholism. Further, I find the inpatient care from December 14, 1981, to December 28, 1981, was not medically necessary nor the appropriate level of care. The record does not document any physical complications associated with alcohol withdrawal that required inpatient treatment beyond the first 21 days of inpatient care. In addition, the beneficiary's alcoholic treatment beyond the first 21 days of inpatient care could have been provided on an outpatient basis. Therefore, the inpatient care subsequent to December 13, 1981, is not covered under CHAMPUS. The beneficiary's CHAMPUS claim for this period of inpatient care and his appeal are denied. In view of this decision, the CHAMPUS Fiscal Intermediary erroneously cost-shared the beneficiary's hospital charges and related attending physician's fees for inpatient care received after December 13, 1981. The Director, OCHAMPUS, is directed to review the claims records and take appropriate action under the Federal Claims Collection Act to recover the erroneous payments. Issuance of this FINAL DECISION completes the administrative appeals process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.


William Mayer, M.D.