



ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

FEB 1 1985

HEALTH AFFAIRS

BEFORE THE OFFICE, ASSISTANT

SECRETARY OF DEFENSE (HEALTH AFFAIRS)

UNITED STATES DEPARTMENT OF DEFENSE

Appeal of )  
 )  
 Sponsor: ) OASD(HA) Case File 84-47  
 ) FINAL DECISION  
 SSN: )

This is the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD(HA) Case File 84-47 pursuant to 10 U.S.C. 1071-1092 and DoD 6010.8-R, chapter X. The appealing party is the CHAMPUS beneficiary who is represented by her father, a retired Navy enlisted man, and who is also represented by counsel. The appeal involves the denial of CHAMPUS cost-sharing for an inpatient psychiatric hospitalization and related care and inpatient psychotherapy at River Oaks Hospital, New Orleans, Louisiana, that began December 6, 1982. Claims were submitted, and denied CHAMPUS cost-sharing, for the period from December 6, 1982, through November 30, 1983. The hospitalization was continuing at the time the hearing was held on May 8, 1984. The amount in dispute is approximately \$1,840 for each month of hospitalization. This estimate is based on monthly billings from the hospital of approximately \$7,500 and for approximately \$1,700 for inpatient psychotherapy from the professional provider. Of the total monthly billings of \$9,200, the beneficiary's other health insurance was paying approximately 80 percent of the total billed charges. The \$1,840 per month unpaid charges total \$22,080 (approximate) for the 12 months from December 6, 1982, through November 30, 1983.

The hearing file of record, the tape of oral testimony and the arguments 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 inpatient psychiatric care and all related medical care from December 6, 1982, through May 8, 1984, be denied CHAMPUS cost-sharing because, "The avowed treatment program of insight oriented psychotherapy with minimal or no use of psychotropic drugs in treatment of paranoid schizophrenia suffered by [the beneficiary] was not in keeping with the generally accepted norm for medical practice in the United States at the time the services were rendered."

The Director, OCHAMPUS, concurs in the Recommended Decision and recommends adoption of the Recommended Decision, with one

exception regarding the period in dispute, as the FINAL DECISION. The Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, concurs in the recommendation of the Hearing Officer except that the denial of care is modified to cover the period ending November 30, 1983, and hereby adopts and incorporates by reference the recommendation of the Hearing Officer as the FINAL DECISION.

The FINAL DECISION OF THE Assistant Secretary of Defense (Health Affairs) is, therefore, to deny CHAMPUS cost-sharing of the appealing party's inpatient psychiatric hospitalization and related charges from December 6, 1982, through November 30, 1983. The Hearing Officer evaluated all the evidence, including testimony at the hearing. This included information regarding the beneficiary's care through May 8, 1984. However, the record contains claims for inpatient care only through December 31, 1983 and the denial being appealed, the OCHAMPUS Formal Review, covered care through November 30, 1983. Therefore, this Final Decision only denies claims through November 30, 1983. It does provide guidance and precedence for subsequent claims.

In my review, I find the Recommended Decision adequately states and analyzes the issues, applicable authorities, and evidence, including authoritative medical opinions, in this appeal. The findings of the Hearing Officer are fully supported by the appeal record. Throughout the appeal process, all physicians who reviewed the treatment of the beneficiary recognized the beneficiary was a severely disturbed young lady. The Hearing Officer recognized that "the beneficiary's parents did [what they did] in order to try and achieve a measure of normalcy and happiness for this very disturbed young woman." The Hearing Officer reached the following conclusion:

"Based upon the peer review opinions of the psychiatrists who have examined this file and the authoritative medical literature which is contained herein, I must conclude that the avowed treatment program of insight orientated psychotherapy with minimal or no use of psychotropic drugs, a treatment of paranoid schizophrenia suffered by this patient was not in keeping with the generally accepted norm for medical practice in the United States at the time the services were provided and, thus, under the CHAMPUS regulation, is not appropriate, medically necessary care."

The Recommended Decision is acceptable for adoption; additional factual and regulatory analysis is not required. The Recommended Decision is hereby accepted as the FINAL DECISION and hereby incorporated by reference, except that it is modified to limit the claims denied CHAMPUS cost-sharing to those for care up to and including November 30, 1983. It is noted that the

beneficiary's mother testified at the hearing that the beneficiary left the hospital in February 1984 on a "medical pass" because it appeared the beneficiary would not be covered by her other health insurance. The beneficiary's mother testified that the beneficiary, during her two weeks at home, was improved compared to her prior condition. The beneficiary's mother further testified that the beneficiary is "better than I've ever seen her" and is in school 3 hours a day whereas before she was in school 1 hour a day. It was not clear whether the beneficiary's mother was referring to the beneficiary's condition at the time of the hearing or to events that had taken place earlier. The beneficiary's mother also testified that when the beneficiary returned from her two-week "pass" in February another physician took over as the treating physician. The record does not include any of the treatment reports or medical records from the present treating physician or any claims. It would not be appropriate in this FINAL DECISION to address the medical necessity of this second physician's care without a proper appeal record first established. The care rendered by Dr. John L. Braud, the treating physician during the period in dispute, as found by the Hearing Officer was not generally accepted care in the United States for the beneficiary's condition. The same type care after November 30, 1983, for the same condition will also be denied, based on the analysis in this FINAL DECISION. However, if the beneficiary's condition has changed, a new factual issue may be presented.

#### SUMMARY

In summary, the FINAL DECISION of the Assistant Secretary of Defense (Health Affairs) is to deny CHAMPUS cost-sharing of the beneficiary's inpatient psychiatric hospitalization and related care at River Oaks Hospital, New Orleans, Louisiana, from December 6, 1982, through November 30, 1983. Since the therapy rendered by the treating physician during the month of November 1983 was cost-shared, the matter of potential recoupment is referred to The Director, OCHAMPUS, for consideration under the Federal Claims Collection Act. Issuance of this FINAL DECISION completes the administrative appeal process under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

  
William Mayer, M.D.

RECOMMENDED HEARING DECISION

Claim for Benefits under the  
Civilian Health & Medical  
Program of the Uniformed Services  
(CHAMPUS)

Beneficiary:

Sponsor :

SSN :

This is the recommended decision of CHAMPUS Hearing Officer Hanna M. Warren in the CHAMPUS appeal of \_\_\_\_\_ and is authorized pursuant to 10 U.S.C. 1079-1089 and DoD 6010.8-R, Chapter X. The appealing party is the sponsor, \_\_\_\_\_, a retired AZC in the United States Navy. The appeal involves the denial of CHAMPUS cost-sharing for inpatient psychiatric hospitalization and related care and inpatient psychotherapy for \_\_\_\_\_ at River Oaks Hospital, New Orleans, Louisiana, from December 6, 1982; which hospitalization was continuing at the time the hearing was held on May 8, 1984. The amount in dispute is difficult to calculate because the care is continuing, but the monthly billings from the hospital were approximately \$7,500 for the hospital charges and \$1,700 for inpatient psychotherapy five times a week with a minimum time of 40 minutes, for a total of \$9,200 a month. Gulf Life Insurance pays approximately 80 percent of the total billed charges, so the amount in dispute would be approximately \$1,840 for each month of hospitalization. Through the month of April 1984, the approximate total would be \$31,280. At the hearing Mr. Cooper was not certain he agreed with that figure and said he would obtain a statement from the hospital and send it to me. Since I did not receive any statement subsequent to the hearing, I assume that figure is correct.

The hearing file has been reviewed along with the testimony given at the hearing and the exhibits submitted at the hearing. It is the OCHAMPUS position that the Formal Review Determination, issued December 29, 1983, denying CHAMPUS cost-sharing of the inpatient hospitalization and related medical care be upheld on the basis that under the CHAMPUS Regulation the care provided was not appropriate, medically necessary care and was custodial care within the provisions of Chapter IV.G.7. The Hearing Officer, after due consideration of the record, concurs in the recommendation of OCHAMPUS to deny CHAMPUS cost-sharing. The Recommended Decision of the Hearing Officer is, therefore, to deny cost-sharing for the beneficiary's inpatient hospitalization and related medical care from December 6, 1982 through May 8, 1984.

FACTUAL BACKGROUND

The young woman who is the subject of this hearing was born November 21, 1963. At age 16, she became depressed, refused to go to school and asked her parents to see a psychiatrist. They took her to a Navy doctor who said she should go to the Community Mental Health Center at Virginia Beach, Virginia, which she did. She was seen by a psychologist, and as her mother testified at the

hearing, "Two days later broke down. She was admitted to the Community Mental Health Center Hospital in January, 1980 in Norfolk, Virginia and was a patient there for five months." The staff told her parents she was having adolescent problems but she was not psychotic. She was given Novane and Nortriptyline and at that time had some problems keeping her thoughts together, but they were told it was not unusual for adolescents. In June, 1980, she was discharged from the hospital and returned to her home. Her mother testified things went well during the summer but in September, 1980, she attempted to cut her wrists and was taken back to the Community Mental Health Center Hospital. The staff said she was resisting treatment at that facility and should be in a hospital away from home, so in November, 1980, she was admitted to Dominion Psychiatric Treatment Center in Falls Church, Virginia. Her father wrote: " became psychotic in December, 1980, and was given enormous amounts of drugs for her symptoms to no avail. We took her out of the hospital on June 23, 1981 because we were moving from Virginia Beach, Virginia to Pensacola, Florida. At this time was hearing voices, paranoid and thinking that everybody knew her and her thoughts." (Exhibit 16). The patient commenced treatment with Dr. Scott Benson as an outpatient on June 30, 1981, in Pensacola, Florida. He kept her on Haldol and Lithium, which was the same medication she had been receiving at the Dominion Psychiatric Center. Dr. Benson became concerned about the patient's condition (Exhibit 25, pages 5 and 6), and in August, 1982, referred her to Dr. Frank Ramos, who was the Director of inpatient services at the Community Mental Health Center, for prolixin injections. The patient was hospitalized for nine days at the University Hospital Psychiatric Ward in September 1982 and again in November, 1982, for approximately one month and at that time was referred to River Oaks Hospital for treatment.

She was admitted to River Oaks Hospital, New Orleans, Louisiana on December 5, 1982. Statements were submitted for the hospital care and related charges and for the inpatient psychotherapy by first Dr. Krimmerman and then Dr. John L. Braud to the CHAMPUS fiscal intermediary, Wisconsin Physicians Service (Exhibit 1). The patient has a new treating physician as of March, 1984, Dr. Martha Wickett and I assume statements have been submitted by her although they are not in the file. By a series of explanation of benefits dated July and August, 1983, the fiscal intermediary denied reimbursement for the services provided and continued denying these except for the psychotherapy care provided by Dr. Braud for the month of November 1983, which was allowed at the amount billed (Exhibit 2, page 8). All other care and services have been denied.

Prior to these denials the fiscal intermediary wrote to the hospital on May 3, 1983 (Exhibit 6), and asked that information be supplied so that peer review might be conducted "for the purpose of determining the medical necessity and adequacy of the care provided". It appears from Exhibit 8 that the hospital records, testing, progress summaries, nurses notes, etc., were sent by the hospital in response to this request. The records were then sent to the American Psychiatric Association Peer Review Project and opinions were given by three psychiatrists around the first part of June.

The first reviewer (Exhibit 7, page 2) found that, although the patient was very sick and care was medically necessary, the level of care was not appropriate. "In my opinion the schizophrenia which this patient is manifesting should more appropriately be treated with aggressive drug treatment and supportive psychotherapy. She should be referred for outpatient work as

soon as practical in order to return to the community." The reviewer found the patient was too ill to benefit from daily psychotherapy which appeared ineffective at the time of the review. The care was not found to be custodial or domiciliary as she was receiving therapy, but in response to the question, "Is the length of stay, frequency or duration of therapy appropriate for the diagnosis?", the answer was: "No. The bias of the treating institution is to offer extremely long-term therapy but I don't think she's a good candidate for this. It is true that the prior hospitalizations failed to help her significantly, but it would appear that with appropriate drug treatment and follow up care and counseling with the parents, she could be tried on drug treatment with short term hospitalization followed by aggressive outpatient follow up. Certainly the daily therapy is not indicated if we consider a full therapeutic hour. Perhaps she should be seen for five or ten minutes a day because this seems to be all that she is able to handle right now."

The second reviewer recommended that the claim be denied (Exhibit 7, page 5). The reviewer found the care to be medically necessary, "secondary to on-going flagrant psychosis that frequently requires restraints even in the hospital situation" and the level of care to be appropriate," in that such patients clearly need a formal psychiatric unit for protection and treatment". He concluded: "The therapeutic program would not seem to be appropriate for the diagnosis in this case in my opinion. The diagnosis of schizophrenia seems to be a stable one by history, examination and psychological testing. Scientific treatment for that disorder includes anti-psychotic medication or EST or both. Psychotherapy alone is not sufficient to my knowledge. I know of no studies that suggest the cost-effective usefulness of multi-year hospitalization for the treatment of schizophrenia." He found the care not to be primarily custodial or domiciliary as the patient was receiving considerable skilled nursing care because of her psychosis. He disagreed with the length of the inpatient stay as not appropriate for the diagnosis and stated: "I don't agree with the treatment program. The frequency of psychotherapy and duration may not be appropriate for the diagnosis at all and certainly are not appropriate without the combined use of other somatic treatments. I am not sure that I can support payment of this hospitalization at all despite the fact that the psychiatrist involved is obviously interested in the patient and trying to help..." The third reviewer recommended that the claim be approved, at least until the six months trial period was completed. He found that the long-term stay projected is "extreme, but worth trying. Though the approach outlined may not be in accord with current chemotherapy practice, I feel that it is justified in view of the psychiatrist's plan for a six-months trial period." (Exhibit 2, page 7)

Although the explanation of CHAMPUS benefit forms are dated August 1983, by letters dated June 9, 1983, both River Oaks Hospital and the sponsor were advised that CHAMPUS was denying cost-sharing based upon the recommendation of the peer reviewers. This denial was based upon CHAMPUS Regulation IV A.10, which is the utilization review and quality assurance provision of the Regulation. After receiving word of the denial of CHAMPUS cost-sharing, both Dr. Braud, the patient's treating physician at River Oaks Hospital and Dr. F. E. Ramos, who had treated her in the Prolixin clinic in Pensacola, wrote letters for the purpose of appeal (Exhibit 10). Dr. Ramos said that the patient had a long-standing history of severe, progressive mental illness and

was referred to River Oaks Hospital "because of her failure to respond to intensive treatment, both as an outpatient as well as after a six-weeks stay on the psychiatric unit of our general hospital. Her psychotic symptoms did not remit in spite of high doses of both Prolixin hydrochloride and Prolixin decanoate along with antidepressant type therapy in adequate doses. Previously she had been under the care of Dr. Scott Benson, a psychiatrist here in Pensacola, who had her on Haldol as well as Lithium also with minimal improvement. It was Dr. Benson's and my opinion that she suffers from severe schizophrenia and that her condition has been following a downhill course over the last few years. Thus I was quite surprised to hear that CHAMPUS consultants did not feel she needed long term psychiatric treatment in a hospital setting." (Exhibit 10, page 1)

Dr. Braud states that it was "precisely because multiple attempts at aggressive drug therapy had proven completely valueless in the past that the patient was referred to River Oaks Hospital for long term intensive psychotherapy." He pointed out that University Hospital, Pensacola, Florida recommended to her family that she be transferred to a long term treatment center because "her mental status did not clear for any significant period of time in spite of IM prolixin and antidepressant medication (Desyrel 300 milligrams a day)." She had numerous previous hospitalizations, one for a period of almost a year at Dominion Hospital and she had a history of not responding well to medication nor to the prior hospitalizations which had ranged from several months to a year. Her treating physician continues:

"I'm also in possession of the discharge summary from Dominion Psychiatric Treatment Center which states that after a couple of months there she 'became increasingly psychotic' and 'her Navane was gradually increased to 35 mgm. a day and Nortriptyline was added and increased to 100 mgm. a day.' Under this regimen 'she became increasingly paranoid and grandiose and she developed auditory hallucinations. ....Her behavior became increasingly violent and uncontrolled and she made unprovoked assaults upon peers. ....The Navane was discontinued and she was started on Haldol which was gradually increased to 91 mgm. per day. Due to her highly impulsive and violent behavior it was necessary to use seclusion and physical restraints at times. ....When she did not respond to high doses of Haldol, she was started on a trial of Lithium Carbonate.' The treating psychiatrist felt the Lithium at 900 mgm. a day was helpful. While acknowledging that 'she continued to maintain some ideas of reference and beliefs that others knew her thoughts' he felt that 'much of her psychotic thinking and behavior had significantly diminished'. Over the same interval the parents, who visited weekly, felt there was no substantive change. continued to take Lithium for about a year under Dr. Scott Benson of Pensacola. He discontinued it, according to the parents, when he finally concluded she had been mis-diagnosed as having a 'major affective disorder

the fact that the Lithium, even when assisted by Haldol, failed to control \_\_\_\_\_'s symptoms. This, in turn, led to \_\_\_\_\_'s re-hospitalization at University Hospital under Dr. Ramos. He initially gave her Prolixin HCL 20 mgm. a day, later switching to 1 3/4 cc (approximately 40 mgm.) of Prolixin decanoate, again with no significant improvement.

"Now it should be noted that 35 mgm. of Navane a day exceeds the manufacturers recommended optimal dosage range for severely psychotic patients of 20 to 30 mgm. a day. The manufacturer of Haldol says that the usual dose range for severe symptomatology is 6 to 15 mgm. a day. In spite of the fact that this is variable, 90 mgm. a day is literally a staggering dosage and only 10 mgm. shy of the manufacturer's maximum permissible. Squibb says 1 cc of Prolixin decanoate every three weeks is equivalent to 20 mgm. a day of Prolixin HCL taken orally; the 1 3/4 cc given by Dr. Ramos equals 40 mgm. a day of Prolixin HCL which is the maximum dose discussed in the PDR and with this caution-'controlled clinical studies have not been performed to demonstrate safety or prolonged administration of such doses'. I think it should now be clear that \_\_\_\_\_ has already encountered 'aggressive drug therapy' several times in the past 3 years and to no avail.

"The recommendation for using EST is even more confusing. I profess no special expertise in this area, but it has been my understanding over the years that while EST is sometimes effective in the treatment of affective psychoses or other illness with severe affective components, it has no place in the treatment of thought disorders. To check that point I put the question to Patrick Dowling, M.D., Medical Director of Coliseum Medical Center where EST is done locally as well as to Roger Anastasio the EST team director there. Both unequivocally confirmed the correctness of my understanding. I doubt that practices prevailing in this community differ substantially from those in the rest of the country, particularly on a subject as sensitive as EST.

In summary, the substantive issue in this case is not whether we should treat the girl with aggressive drug therapy or intensive psychotherapy. Rather, it is whether we should immediately consign this 19 year old to the Florida State Mental Hospital at Chattahoochee for permanent custodial care or first give her a chance at intensive psychotherapy. This is the only real choice, and, unfortunately, it seems to have entirely eluded the learned reviewers."



These letters from Dr. Ramos and Dr. Braud were sent for a second opinion to the two peer reviewers who had originally denied the care. The first reviewer finds she was being treated with Meloril and she did show some improvement; "It was my feeling and belief at the time of the review and continues at this time to be that she be treated with drugs and with supportive psychotherapy considering the description of her mental status during the period of time she has been in intensive therapy." The reviewer concludes that the treatment was medically necessary because "she is a very sick and disturbed patient" but that in his opinion the level of care is not appropriate nor is the therapeutic program appropriate for the diagnosis. He did not find the care to be custodial because she was "receiving daily intensive therapy and also much milieu therapy." This reviewer again states he does not believe she is a good candidate for long-term therapy. "It is true that the prior hospitalizations failed to help her significantly but it would appear that with appropriate drug treatment and supportive psychotherapy and counseling with her parents she could be tried on short-term hospitalization at this time." He felt that the full therapeutic hour was not indicated, perhaps she could be seen briefly as that is all she was capable of handling. "I continue to feel the patient is in need of hospital therapy but I would recommend it in a short term therapy unit and continue with medication as a primary rather than a secondary tool." (Exhibit 3, page 7)

The second reviewer again recommends that the claim be disapproved while stating: "From the new information it seems clear that adequate trials of antipsychotic medication have been made. In my opinion EST remains the next most likely treatment to succeed in securing a remission from psychosis at least temporarily. Sometimes after that remission is achieved, however brief, the medications will then hold the patient in remission whereas they were not successful initially." This reviewer states that to his knowledge long-term intensive inpatient psychotherapy "is not likely to make much of a difference in the case of chronic nuclear schizophrenia as is described herein." The reviewer adds that he feels this case is really dealing with a policy question that should be addressed at a higher level with more contributing opinions. He questions whether "the tremendous expense of a multi-year inpatient psychotherapy program is a reasonable effort on the behalf of a patient with chronic nuclear schizophrenia. From what I know (and it may not be enough) I would doubt it." (Exhibit 13, page 4).

Both the hospital and the sponsor were notified that the CHAMPUS cost-sharing denial would be upheld based on the second peer review (Exhibit 15, page 1 and 3) and both requested a formal review (Exhibits 16 and 19). A letter was also written to the fiscal intermediary regarding this patient from the Clinical Director of River Oaks Hospital (Exhibit 17). He stated that the patient had multiple hospital admissions with long trials of medication. She was referred "for an attempt at a thoroughgoing psychotherapy in a designed psychiatric milieu." He reported numerous successes at this and other hospitals for young patients with her diagnosis and "a high percentage have been successfully returned to the community. This long term psychotherapy is her last best chance and is obviously, in my opinion, making significant gains."

Before the Formal Review Decision was issued, the medical file was reviewed by the OCHAMPUS Medical Director who is a Board Certified Child Psychiatrist (Exhibit 20). He stated: "Almost without exception an individual with a disorder such as schizophrenia needs to be on psychotropic medication. Such a person can nearly always be stabilized on medication for a period of three to ten days. These patients are generally not considered to be good candidates for insight oriented psychotherapy...where a person is chronically and floridly psychotic, as in the instant case, an acute care facility with its emphasis on changing behavior is not appropriate." He found in his review of the records that she was not able to function adequately in the home or in outpatient therapy and although she was treated by some of the finest psychiatrists in the country, she continued to deteriorate and failed to respond to medication. He reports that many years ago the type of treatment being afforded to this patient, wherein they would be hospitalized for lengthy periods of maybe several years duration and treated using psychoanalytic techniques with little or no medication, was the predominant mode of treating severely disturbed patients with schizophrenia and manic depressive disorders, but concludes: "It is very clear now on the basis of empirical studies and research findings that long term intensive psychotherapy is not the treatment of choice in cases of this type. As a method of treating such disorders it is no longer considered efficacious." It was his opinion that patients such as the one involved in this hearing require "heavy dosage medication in a long term hospital setting where they can be afforded protection from themselves. There are some individuals who can be treated effectively on an outpatient or partial hospitalization basis following such long term treatment in a state hospital or similar setting." He concludes that while the patient needed institutional care, "the type of care provided was neither appropriate nor the treatment of choice."

Dr. Rodriguez, the OCHAMPUS Medical Director, also found the patient's condition was expected to continue and be prolonged as she was severely psychotic with a very poor prognosis. She also required a protective, monitored and controlled environment in that she remained on visual contact for suicide prevention. "She also required assistance to support the essentials of daily living--most notably she frequently required restraints to sleep." He concluded that, "While she was under active and specific treatment, it was not the type of treatment which could reasonably be expected to reduce her disability to the extent necessary to enable her to function outside of a protected monitored and/or controlled environment."

The Formal Review Decision issued December 29, 1983 (Exhibit 21) denied CHAMPUS cost-sharing for the inpatient hospitalization and related inpatient psychotherapy from the date of admission on the basis that the acute psychiatric inpatient level of care and the related psychotherapy were not medically necessary or at the appropriate level for treatment of the patient's diagnosed condition. Mr. Algia R. Cooper, on behalf of the sponsor, filed a request for hearing (Exhibit 22). A hearing was held May 8, 1984 before OCHAMPUS Hearing Officer Hanna M. Warren, Mrs. \_\_\_\_\_ and Algia R. Cooper, attorney at law. Gary Fahlstedt attended the hearing representing OCHAMPUS.

## ISSUES AND FINDINGS OF FACT

The primary issues in dispute are whether the care provided the appealing party was medically necessary and appropriate care as described in DOD 6010.8-R and whether the care was custodial care as described in Chapter IV E.12. of that Regulation. Secondary issues that will be addressed are related care and burden of evidence.

Chapter 55, Title X, United States Code, authorizes a health benefits program entitled Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Department of Defense Appropriation Act of 1979, Public Law 95457, appropriated funds for CHAMPUS benefits and contains certain limitations which have appeared in each Department of Defense Appropriation Act since that time. One of the limitations is that CHAMPUS is prohibited from using appropriated funds for "...any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury or body malfunction as assessed or diagnosed by a physician, dentist, or clinical psychologist..."

Department of Defense Regulation DoD 6010.8-R was issued under the authority of statute to establish policy and procedures for the administration of CHAMPUS. The Regulation describes CHAMPUS benefits in Chapter IV, A.1 as follows:

"Scope of Benefits - Subject to any and all applicable definitions, conditions, limitations and/or exclusions specified or enumerated in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians and other authorized individual professional providers, as well as professional ambulance service, prescription drugs, authorized medical supplies and rental of durable equipment."

Chapter II of the Regulation, Subsection B, 104, defines medically necessary as "the level of services and supplies, (i.e., frequency, extent and kinds), adequate for the diagnosis and treatment of illness or injury. Medically necessary includes concept of appropriate medical care." Chapter II, 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," where the provider is qualified and licensed and "the medical environment where the medical services are performed is at the level adequate to provide the required medical care."

Chapter IV, paragraph G provides in pertinent part: "In addition to any definitions, requirements, conditions and/or limitations enumerated and described in other Chapters of this Regulation, the following are specifically excluded from the CHAMPUS Basic Program:

1. Not Medically Necessary. Services and supplies which are not medically necessary for the diagnosis and/or treatment of a covered illness or injury...

3. Institutional Level of Care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care...

NOTE: 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.B. specifically covers institutional benefits and provides scope of coverage and exclusions. The requirement of care rendered at an appropriate level is repeated in paragraph (g): "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..."

Chapter IV.A.10. provides in pertinent part as follows: "Utilization review; Quality Assurance. Prior to the extension of any CHAMPUS benefits under the basic benefits program as outlined in this Chapter IV, claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS, is responsible for utilization review and quality assurance activities and shall issue such generally accepted standards, norms and criteria as are necessary to assure compliance. Such utilization review and quality standards, norms and criteria shall include, but not be limited to, need for inpatient admission, length of inpatient stay, level of care, appropriateness of treatment, level of institutional care required, etc...."

Chapter IV.E.12. provides in pertinent part as follows:

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

"a. Definition of Custodial Care. Custodial Care is defined to mean that care rendered to a patient (1) who is mentally or physically disabled and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored and/or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical and/or psychiatric treatment which

will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored and/or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising and/or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, and/or provide for the patient's comfort, and/or assure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a R.N., L.P.N. or L.V.N.

"b. Kinds of Conditions that Can Result in Custodial Care.

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

Before I begin my discussion of the rationale for my decision to deny benefits, I want to address two preliminary issues. The first is the argument raised at the hearing by Mr. Cooper that the treating physician of this beneficiary has evidenced some strong bias against the CHAMPUS program and has allowed his personal bias to interfere with an appropriate response to CHAMPUS requests for information and his response to prior determinations. He pointed this out because of his concern that the peer reviewers might have been somewhat prejudiced by the physician's attitude and a few unkind remarks he made about the peer reviewers. I want to assure the appealing party and their attorney that I have not felt any bias or prejudice towards the treating physician because of his remarks. It is clear that he is, as Mr. Cooper stated, traditionally psychoanalytically oriented. There is nothing wrong with this position and the record is clear he is greatly concerned about this patient and is trying to do the best thing to help this young woman deal with her serious illness. I do not believe the fiscal intermediary or CHAMPUS, or certainly I in making this decision, intend at all to imply that his motives are not the best and he is doing what he clearly believes is best for this young woman. Under those circumstances all of us as human beings probably tend to get a little testy when anyone says what we are doing might not be the best treatment for the person we're trying to help. In this human context, I do not believe his responses were out of line. The record is clear that several different treatment regimens have been tried on this patient with little success. I have given a great deal of thought to my decision because of this past history. I can certainly understand wanting to try anything that might help, but I must follow the requirements for CHAMPUS coverage. I cannot ignore the impartial peer review opinions nor the authoritative medical articles in the hearing

file, all of which conclude that long term psychoanalytically oriented therapy have not been shown to be efficacious for patients with a diagnosis of paranoid schizophrenia.

The other issue I want to discuss is related to the comments about the treating physician. I am not deciding whether the care rendered to the beneficiary was the best for her or whether other care would have been better. A decision regarding medical care is one which is always, and rightly so, made between the physician and his or her patient. My decision does not concern whether the choice of care was proper, but only concerns whether that care can be reimbursed under the constraints of the CHAMPUS Law and Regulation. CHAMPUS is not an insurance program but a benefits program, and as such is always an "at risk" program. Care is provided, claims are submitted and a determination is made regarding whether cost-sharing can be allowed under the Appropriations Act, the CHAMPUS Law and the Regulation published pursuant thereto. Congress appropriates funds to pay for CHAMPUS coverage and every Appropriations Act has certain restrictions. Coverage constantly changes but the overriding necessity is that the care be medically necessary and rendered at the appropriate level. Again, as Hearing Officer, I am making no decision regarding the quality of care or the decision made by the physicians and the beneficiary's parents. I am only applying the restraints of the CHAMPUS Law and Regulation to the record in this case. I can assure you that as I examine this file I would probably have done exactly the same thing the beneficiary's parents did in order to try and achieve a measure of normalcy and happiness for this very disturbed young woman. I was very pleased at the hearing when her mother stated she had improved and did not seem to be dillusional any longer. It is a very difficult decision for me to make as Hearing Officer and I honestly wish that I could just say CHAMPUS should pay for all care not reimbursed by the primary insurance carrier. Because I am bound by the Law and Regulation and because the Regulation provides that all claims for benefits under the CHAMPUS program should be adjudicated in a "consistent, fair and equitable manner" (Chapter I.P.), I must apply the regulatory requirements to the record in this case. Because the patient has shown some improvement, although after a year and a half of hospitalization, it encourages me to "after the fact" allow benefits, but my decision as to medical necessity and appropriate care cannot in fairness be based on whether the patient's condition improved or worsened. Using that as a standard would really be inequitable.

Under the CHAMPUS Law and Regulation given above and because of the need for CHAMPUS to be fiscally accountable and provide answers both to the Department of Defense and beneficiaries to questions about quality of care delivered by civilian health care professionals, it was necessary to establish some method of review. The CHAMPUS peer review project developed in relation to that need. Because of the frequent length of treatment and the diversity of treatment methods, it is difficult for lay people and fiscal intermediaries to apply a standard criteria by which medical/psychological necessity is determined. In response to this, the American Psychiatric Association and American Psychological Association Peer Review Projects were undertaken. It is for this reason that I have discussed in detail the substance of the peer reviews in this hearing file.

The care provided to the beneficiary in this hearing was the subject of six different reviews by four different psychiatrists, three of whom were acting under the American Psychiatric Association Peer Review Project and one of whom is the Medical Director of OCHAMPUS. Only one of these psychiatrists felt the treatment at River Oaks Hospital was appropriate for the patient described in this hearing and even that reviewer admitted the approach outlined in the hospital's records was "not in accord with current chemotherapy practice". The other three psychiatrists who examined the file all agreed the diagnosis was correct and that in December, 1982, the patient needed psychiatric hospitalization. They also agreed that the projected long-term hospitalization with minimal anti-psychotic medication and treatment with daily intensive psychotherapy was not an appropriate level of care for a patient with the type of symptoms presented by the beneficiary. The definition of appropriate medical care bears repeating as it is defined as "medical care where the medical services performed in the treatment of disease or injury are in keeping with the generally acceptable norm for medical practice in the United States." Dr. Rodriguez stated: "Where a person is chronically and floridly psychotic as in the instant case, an acute care facility with its emphasis on changing behavior is not appropriate." Dr. Rodriguez is not only a Board certified psychiatrist, but is also a fellow of the American Board of Quality Assurance and Utilization Review Physicians. This is an area in which he has considerable expertise as shown by Exhibit 20 and I believe his evaluation of the treatment process and the current status of medical thinking is thoughtful and supported by other material in the hearing file. I think it is fair to say that even Dr. Benson, who treated this young woman for over a year and obviously felt great concern for her, as shown by the material in Exhibit 31, feels pessimistic about the care being rendered when he states: "We're all reluctant to consider placing \_\_\_\_\_ in the state hospital but I find that little different from allowing her to continue her suffering at River Oaks."

In addition to the opinions from the peer reviewers, Exhibit 24 is Kaplan and Sadock, Comprehensive Textbook of Psychiatry/III (Williams and Wilkins, May 1983) and in Section 13.6., Schizophrenia: Overview of Treatment Methods, it reports as follows under psychotherapy: "In general, orthodox formal psychoanalysis has no place in the treatment of overt psychosis, although some rare patients may recover sufficiently to be suitable for analysis if restitution is complete and consolidated. Nor is formal psychotherapy of the kind commonly used for neurotics likely to be of much help in the treatment of the hospitalized or still psychotic patient. Formal psychotherapy, as distinguished from psychotherapeutic management, should be reserved for the outpatient, postrestitution phase of treatment, when the patient is in good contact with reality, able to communicate, and likely to understand rationally" (at page 335). Under the section entitled "Drug Therapy" the textbook author states: "A few therapists still believe that drugs have no place in the treatment of schizophrenia and that drugs are incompatible with psychotherapy and psychosocial methods of treatment. However, this resistance is steadily passing into history" (at page 337).

There is also an exhibit in the file (Exhibit 30) which is the an article from the April 1976 issue of the Archives of General Psychiatry. This article is a follow-up study of hospitalized patients for treatment of schizophrenia. It is a very detailed review as to the status of patients from one to five years after first admission and after first release. A review of the article

consistently shows that patients who were treated with psychotherapy alone had consistently longer stay periods than all other treatments at all points in time in all reverse cohorts (page 485). In the comment the authors stated: "A major finding was that patients who were originally treated in hospital with psychotherapy alone stayed, on the whole, significantly longer in hospital over the entire follow up period than those who received ECT, drug alone or drug plus psychotherapy. This applied whether the follow up was dated from admission or from release; it applied across all patients as well as for those whose treatment in the hospital had been declared to be a success" (Page 486).

Exhibit 29 is an article from the September 1976 issue of the American Journal of Psychiatry and is a discussion of the results of a review of controlled studies of treatment approaches to schizophrenia. The article first discusses milieu care and rehabilitation finding, "There was reasonably good evidence that inpatient milieu treatment programs produced beneficial results. The programs that were effective had concentrated on real life problems and on planning for discharge. There was little evidence that other types of in-hospital milieu programs were effective in the treatment of schizophrenic patients" (at page 1009). In the discussion of psychotherapy it states: "A breakdown into inpatient versus outpatient according to type of therapy is illuminating. The balance of the evidence suggests that inpatients treated with individual psychotherapy aimed at psychological understanding did not improve more than a control group. By contrast, group therapy that was focused on reality or on a group activity was more effective than a control treatment and more effective than group therapy aimed at psychological understanding" (at 1009). In discussing outpatient psychotherapy, they found group therapy to be more effective than individual therapy. "Positive results were obtained particularly when treatment had focused on social and occupational rehabilitation, on problem solving, and on cooperation with pharmacotherapy--i.e., successful treatment was oriented more towards support and rehabilitation than toward formal attempts to promote insight and deeper psychological understanding." The article continues: "The greatest evidence that therapeutic effect was gained by anti-psychotic drug therapy which scored many thousands of D-R points" and the comment stated: "The evidence in favor of the efficacy of pharmacotherapy was overwhelming." The article went on to say that drugs alone are unlikely to be sufficient for optimal results but "there was only modest evidence that inpatient milieu and group psychotherapy programs were of benefit, and then largely they center around some kind of activity or focused on discharge planning and social and occupational rehabilitation. There was, however, four times as much evidence in favor of outpatient care along similar lines. In fact day care or home care when feasible, produced better results than inpatient care" (Page 1009). The author discusses the nature of the way drugs work and does not agree they only reduce anxiety in a superficial way. He states: "This is not in line with the evidence from controlled studies showing drugs affect the primary symptoms of schizophrenia more than the secondary ones. The implication is that anti-psychotic drugs reduce psychotic distortion of reality and thus reduce the anxiety secondary to that distortion. It is reasonable to assume that life-time patterns are not likely to be easily modified, and to be suspicious of any suggestion that short-term treatment of any kind can promote radical change. But there is virtually no information available about change at 'deeper levels' over a prolonged period resulting from any type of therapy, and certainly no experimental support for the notion that more such change occurs



during psycho-social treatment than during an equivalent period of drug therapy" (at 1010). In discussing the limitations of non-drug therapies, the author states: "For example, milieu therapy can have toxic anti-therapeutic effects particularly when techniques and methods developed for neuroses and character disorders are indiscriminately applied to psychotic patients. For patients who have defects in perception, attention, and information processing or who are disorganized and hyperaroused, the typical milieu ward, with its high stimulus input, lively group meetings, role diffusion, searches for hidden meanings, loud noise, and inability to distinguish staff from patients by dress may constitute a toxic dose of environmental stimulation. Delayed toxic effects may also occur. Patients tend to conform to an institutional culture, whatever it may be. What happens when patients adjust to a hospital society that is radically different from the outside world? Psychotherapy can make some patients worse, especially when there is a negative transference or serious countertransference. Destructive acting out may occur when inhibitions are lifted ...."(at 1011).

I have also considered the article submitted at the hearing by the attorney for the appealing party (Exhibit 32). It is from Psychology Today, February 1981, and is entitled "The Promise of Biological Psychiatry." The article in the first paragraph states: "In facing the puzzle of mental illness, psychiatric savants of the first half of the twentieth century believed that Freudian theory will provide the answers. However, in the second half of the century, scientific research has uncovered evidence that biological malfunctions are central to mental illness and that much of the now entrenched psychodynamic theory is irrelevant or even misleading." The article examines in depth the biological basis for mental illness and concludes: "We think that the antipsychotics, the antidepressants, and Lithium are not 'masking' the symptoms of an illness, nor are they directly correcting the 'underlying cause'. They are relieving the symptoms by normalizing some deep malfunctioning closely related to the underlying causes. They are not second class therapy, they are the best therapies we have now" (at page 41). Although this article was sent by Dr. Benson to Mr. Cooper, I think it tends to support the position of the peer review doctors and their concern that emphasis was not placed upon drug therapy and short term hospitalization in the treatment of this young woman.

I want to note that I have examined all the material brought to the hearing by Mr. Cooper and submitted as exhibits 31, 32 and 33. Exhibit 31 are the medical records Dr. Benson kept regarding this patient during his time he treated her and consists mainly of correspondence, much of which was already contained in the hearing file. This same is true for Exhibit 33, which are the hospital records. These records do contain material which was not originally in the hearing file and update the progress notes and nurses notes through February of 1984. I have examined all of this material and find nothing significant to the issues in this hearing which was not available to the peer reviewers. The point was made at the hearing by Mr. Cooper that the basis for denial of CHAMPUS benefits was that drug therapy was not utilized and he stated that, in his opinion, Dr. Braud belonged to a traditional school in which psychotherapy was the only way of treatment and while the recent literature shows that drug therapy is the treatment of choice, it may not be the only choice. He pointed out that she did not do well when she was tried previously on medications and that I should consider that, even though the psychiatrists said psychotherapy

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is the way to treat, he continually used drugs in the treatment process. It is true that the initial treatment plan of the admitting physician, Dr. Krimerman, was that medications would be continued "so as not to precipitate more decompensation". They were to do a work-up and try and identify any other medical problems and the fourth goal was stated to be "another goal at this time is to try to establish rapport with the patient to obtain further history and to assess her capacity to relate and make use of intensive psychotherapeutic techniques (Exhibit 8, page 4). The diagnostic evaluation, psychiatric summary states for treatment plan: "I would estimate that would need to be in the hospital approximately three years, perhaps longer. Treatment needs include long-term intensive psychotherapy for with probable reduction of her psychotropic medication in the near future so as to give her an opportunity to be treated without such medication" (Exhibit 8, page 13). This same report indicates that the family was concerned about her need to be taken off medication gradually rather than abruptly. There is an addendum to this report that states the patient was seen by Dr. Levy in a psychiatric consultation during her evaluation and that his diagnosis was paranoid schizophrenia. "He felt that because of her poor impulse control and lack of psychological mindedness, she could not engage in outpatient psychiatric treatment and should be given a trial in intensive psychotherapy." (Exhibit 8, page 14). In addition the monthly progress summary and treatment plan first filed by Dr. Braud for the period January 1983 states: "I have agreed to a six months trial of intensive psychotherapy." He said at that point there must be some indication of progress in that "she must be able to assist in her own recovery with some observing ego and some genuine affects so that my efforts as well as those of the staff do not appear useless." The treatment plan continues: "On River Oaks Hospital intensive treatment units therapists rely primarily upon an intensive psychotherapy. For the most part drug therapy (neuroleptics) are not used and for the remainder only ancillary agents to the psychotherapy. Consistent with this philosophy is being weaned off prolixin, and neuroleptics will be reinstated only if felt to be absolutely necessary." (Exhibit 8, page 20). The physician's orders show this was done and the prolixin was gradually reduced to 25 mgm. by January 12, 1983 and the last injection of 12.5 mgm. given February 8, 1983 (Exhibit 8, page 28). On February 23, 1983, Mellaril administration was commenced, but at a very low dosage (Exhibit 8, page 28). The monthly progress summary and treatment plan for March, 1983, notes this medication: "The Mellaril 50 mgm. BID, has had a more pronounced effect than I anticipated." (Exhibit 8, page 4). It is the appealing party's position that medication was given during the entire hospitalization, which is true, but I don't think it is accurate to say this treatment plan is similar to the ones described in the medical literature as having primary drug therapy with supportive psychotherapy or group therapy. The reviewing psychiatrists had copies of the physicians orders through May 1983, and were aware that the patient had received prolixin for a certain period of time to gradually titrate her off that medication and also that she had received low levels of Mellaril during the entire time of her hospitalization. In my opinion the medical records make it clear that the primary focus of the treatment program was long term intensive psychotherapy with medication given only ancillary and, in this case, at very low dosage levels.

The appealing party suggested that more weight should be given to the opinions of the doctors who actually treated the patient than to that of the peer reviewers who never examined her or discussed her treatment with her doctors. I

agree this is something that should be considered by me in making my decision and I have done so in this hearing. Thoughtful consideration of the argument that the peer reviewers should examine the patient will show this is not workable. The reviewers are making determinations regarding medical care rendered at a time previous to their review, sometimes by many months. In all cases, medical, surgical, psychiatric, etc., the patient will almost always be in a very different stage than when the care was rendered. For that reason all peer review must of necessity rely on the medical records. The records in this case are complete and extensive and these were available to the reviewers at the time they made their decisions. We have a letter from Dr. Benson who treated this beneficiary on a outpatient basis for approximately one year (Exhibit 25, page 12) and I believe it is fair to say he shows some concerns about her then present treatment at River Oaks Hospital. We also have a letter from Dr. Ramos who was the psychiatrist involved with the outpatient Lithium clinic (Exhibit 10, page 1). He recounts her past treatment, but gives no rationale for her present treatment, other than she was a very disturbed young woman and many other treatments had been tried, with little success. I have discussed the records of her treating physicians and we also have a letter from Dr. Sorum, the clinical director of River Oaks Hospital (Exhibit 17, page 1). He describes the treatment approach as "throughgoing psychotherapy in a designed psychiatric milieu" and states this is her last best chance. I must also consider that all of the physicians on the staff of River Oaks Hospital would be presumed to adopt their treatment philosophy as described by Dr. Sorum. This presumption must be weighed against the fact that the impartial peer reviewers did not actually examine or treat the patient.

Based upon the peer review opinions of the psychiatrists who have examined this file and the authoritative medical literature which is contained herein, I must conclude that the avowed treatment program of insight oriented psychotherapy with minimal or no use of psychotropic drugs in treatment of paranoid schizophrenia suffered by this patient was not in keeping with the generally accepted norm for medical practice in the United States at the time the services were provided and thus under the CHAMPUS Regulation is not appropriate, medically necessary care.

The statement of OCHAMPUS Position raises the issue that the care provided to the beneficiary during her hospitalization was custodial and thus excluded under the custodial care exclusion of the CHAMPUS Regulation, Chapter IV.E.12. It is their position (based primarily upon the opinion of the OCHAMPUS Medical Director (Exhibit 20, page 2)) that the care was custodial because the patient was "severely psychotic with a very poor prognosis." Thus her condition was expected to continue and be prolonged. She also required a protected, monitored and controlled environment in that she was constantly on visual contact for suicide prevention and she required assistance to support the essentials of daily living. "Most notably she frequently required restraints to sleep." Although she was under active psychiatric treatment, the Medical Director stated "It was not the type of treatment which could reasonably be expected to reduce her disability to the extent necessary to enable her to function outside of a protected, monitored and controlled environment."


It is very difficult for me as Hearing Officer to believe this is the type of care that was meant to be included within the Regulation prohibiting cost-sharing for custodial care. I agree with the position taken by OCHAMPUS

initial adverse decision. Chapter X, F.16(h) and (i). I have concluded the appealing party has not met this burden as regards the care provided in this hearing. The record supports the OCHAMPUS determination that the treatment plan of insight-oriented psychotherapy, with little or minimal use of drug therapy, was not the generally accepted norm for medical practice in the United States at the time the services were rendered and thus was above the appropriate level of care and not medically necessary under the provisions of the CHAMPUS Law and Regulation. As to the issue of custodial care, it is my decision the appealing party, by testimony at the hearing, has met this burden showing the care not to be custodial.

SUMMARY

It is the recommended decision of the Hearing Officer that inpatient psychiatric hospitalization at River Oaks Hospital and all related medical care from December 6, 1982 through May 8, 1984 be denied CHAMPUS cost-sharing as it was not appropriate, medically necessary care under the CHAMPUS Law and Regulation.

Dated this 2<sup>nd</sup> day of July, 1984.

  
HANNA M. WARREN  
Hearing Officer