

# P&S Network, Inc.

P.O. Box 48425, Los Angeles, CA 90048

Ph: (310)423-9988 Fx: (310)423-9980

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/18/2007

**IRO CASE #:**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This case was reviewed by a psychiatrist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Residential substance abuse treatment for 11-12-07 through 11-21-07

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o November 12, 2007 letter from M.D.
- o November 15, 2007 letter from M.D.
- o November 25, 2007 letter from M.D.
- o October 24, 2007 plan report for the patient not signed
- o November 12, 2007 through November 21, 2007 chart notes
- o November 29, 2007 letter
- o the 26 2007 letter by M.D.
- o November 28, 2007 letter
- o November 28, 2007 letter by M.D. September 28, 2007 through November 15, 2007 chronology of events
- o November 9, 2007 through November 15, 2007 nurse case management notes
- o November 27, 2007 corrected letter from M.D.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records contained a November 12, 2007 utilization review report which renders a non-certification for an extension of care. The report states that the extension is not justified by the clinical data beginning on November 9, 2007. The reviewer stated that there is no evidence the patient cannot apply coping skills sufficient to maintain abstinence from chemical substances without a structured program after November 8, 2007.

A November 15, 2007 utilization review letter certified the dates of service of November 9, 2007 through November 11, 2007. The report states that there is evidence that the patient cannot apply coping skills sufficient to maintain abstinence from chemical substances without a structured program through November 11, 2007. The reviewer noted that the patient seems to have

reached the point of having picked up skills to stay sober. He is motivated and the issues of lack of friends could be addressed as an outpatient. The patient had family weekend last week and that went well. The reviewer stated that a stay beyond November 11, 2007 does not seem to be supported by the Texas Commission on Alcohol and Drug Addiction Residential Treatment Center Program Medical Necessity Criteria after November 11, 2007.

A November 25, 2007 appeal letter was submitted by the residential facility. The letter states that at the time of the denial, the patient's diagnoses were as follows: Axis I: Cannabis dependence, alcohol abuse, opioid abuse, sedative, hypnotic or anxiolytic abuse, attention deficit hyperactivity disorder, predominantly inattentive type Axis II: None, Axis III: None, Axis IV: Problems with primary support group, educational problems, legal problems, Axis V: GAF 40.

The letter states that at the time of the denial, the client had relapsing cravings for marijuana. The client stated that he feared not having friends in recovery. The counselors noted that the patient's fears were irrational and they worked with him regarding rational emotive behavioral therapy (REBT) and thought stopping to reduce his fears and cravings. The client was inconsistently applying the techniques and thought stopping to his fears and cravings, and he required staff redirection to reduce them. An additional week of treatment was requested in order to strengthen the client's use of REBT and thought stopping. In a family session on November 12, 2007, the client's father felt that the client needed to stay in treatment at the facility to improve his ability to reduce his cravings and fears. He did an individual session on that same date and the client stated that he wanted to be sober, but did not feel that he could make progress on reducing his anger, fears, and cravings. On November 13, 2007, the patient stated that he had a newly found commitment to recovery due to improvement in his family conflict. On November 13, 2007, the counselors discussed with the patient his sleeping in school. He was not felt to have a diagnosis of Antisocial Personality Disorder, but was having antisocial behaviors. Due to the client's sedation, his morning dose of Seroquel was discontinued on November 14, 2007.

On November 20th, 2007, the client feared having to reject his friends who were still using drugs and was fearful of discharging to the Imagine Program. On November 21, 2007, the staff psychologist saw the client for processing of his anger which resulted from others distancing themselves from the client. The client appeared to be motivated toward using REBT in treatment and was showing new coping skills and displaying less antisocial traits. He was discharged on November 21, 2007 on Strattera 60 mg in the morning and Seroquel 150 mg at bedtime.

A November 20, 2007 utilization review letter provides an opinion that agrees that the patient appeared to have received maximum benefit from 45 days of residential treatment. The continued stay exceeded the intensity required for treatment of the chemical dependency and mental health issues. The report opines that the patient could safely and effectively receive treatment at the intensive outpatient level of care which is available in his home area.

A November 29, 2007 letter was submitted by the patient's parents. The letter details the patient's history of behavior and substance abuse. The history stated that the patient was admitted to a residential treatment facility as the patient's drug use was escalating to risky behavior that was endangering his life. The letter states that family life became "non-existent" with much stress, anger, anxiety, sleepless nights, and inability to function and normal daily activities. The patient sustained an apparent drug-induced blackout and was taken to the residential facility. The letter states that the patient gained 17 pounds in his first two weeks there. He was very angry about the treatment and wanted the parents to take him home. He felt that he did not have a problem or if he did, he could fix it at home. Working with the counselors and staff, the patient began to recognize that he had a drug problem. He came clean about his drug abuse, stating that he tried every illegal drug possible. After a month, the parents noted some changes in their son. Additional testing was done to validate his diagnosis. The residential facility was reportedly able to educate the patient and the parents about the illness and issues. The facility was able to help restore the family. As of the date of the letter, the patient continued care in an intensive outpatient program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

After thoroughly reviewing this case and based on my clinical experience, I do not agree with the previous determinations to non-certify the dates of service in question. The patient had cravings, slept in school, was fearful of discharge, and had issues with his friends/"support network." He was prompted by the therapist to utilize therapy. There was not sufficient improvement by November 12, 2007 to allow for discharge. Per the TCADA Criteria 3.8011 (B) Category 2, (i), the patient manifested severe social isolation or withdrawal from social contacts.

My opinion is that the previous adverse determination should be overturned, as I disagree with it. Therefore, my determination is to overturn the previous decisions to non-certify residential substance abuse treatment for 11-12-07 through 11-21-07.

The IRO's decision is consistent with the following guidelines:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

\_\_\_\_ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

\_\_\_\_AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

\_\_\_\_DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

TCADA Criteria: 3.8011. Admission Criteria for Inpatient Rehabilitation/Treatment:

(B) Category 2: Family, Social, Academic Dysfunction and Logistic Impairments- Met/Not Met. The patient does meet the criteria of at least one clause out of clauses (i)-(v) of this subparagraph.

(i) The patient does manifest severe social isolation or withdrawal from social contacts.