

# Parker Healthcare Management, Inc.

**DATE OF REVIEW:** MARCH 2, 2007

**IRO CASE #:**

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

Medical necessity of the mental health residential treatment from 2.16.07 to date of review determination 3.2.07

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Psychiatry, and is engaged in the full time practice of psychiatric medicine.

## **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	IRO Decision
296.80	MH residential Tx		Concurrent		2.16.07-3.2.07	Overturn Denial

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

TDI-Request for an IRO

Respondent records- a total of 126 pages of records received to include but not limited to: letter, 2.27.07; Request for an IRO, 2.21.07; Case summary, LPN, 2.22.07; Criteria/guidelines; letter, 2.16.07, 2.16.07; event profile printout; certificate of coverage

Requestor records- a total of 201 pages of records received to include but not limited to: Complete medical records from center to include social assessment/history, group notes, progress notes, physician notes, nursing notes from 1.25.07- 2.25.07 ; Patient notes 1.12.07-1.13.07

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

The patient is a student admitted to a psychiatric hospital because of mood swings and escalating behavioral problems including anger, aggressiveness, threatening his mother and the police, deceptiveness and sexual promiscuity. He had been charged with two misdemeanors, in December, 2006 and January, 2007, with a charge of assault. He had used alcohol and marijuana to an unknown extent. His school performance had deteriorated from being an A student up to 2004, to getting Cs, Ds and Fs prior to admission.

The patient was adopted at birth, and no information about his biological parents or other relatives is available. His adoptive family included the adopting parents and their biological daughter, older than the patient, currently living out of state. He has a good relationship with the sister and misses her. The patient's adoptive father committed suicide by overdose on the patient's birthday. He had reportedly been close to the father, who had a history of drug abuse. The patient had a motorcycle accident in August, 2005, sustaining a concussion with loss of consciousness. He had his first grand mal seizure in December, 2005, and in 2006 was given the diagnosis of epilepsy. Additional past history includes much delay in toilet training, not really completed until he was old. Before his hospital admission he had been in outpatient psychiatric treatment, and had not been compliant with medications.

On days in the hospital he was transferred to a residential treatment center. It is his treatment in the that is under review. The patient's insurance carrier denied coverage for his treatment beyond 2/15/07 as being, in its reviewer's opinion, not medically necessary. That denial decision has been appealed, upheld by the insurance company, and appealed further for review by this Independent Review Organization.

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

On admission to the the patient was alert, oriented, cooperative, had good eye contact, his thinking was logical and goal-directed, he denied delusions, hallucinations, suicidal or homicidal ideation. Diagnoses included Bipolar Disorder NOS, ADHD Inattentive type, and epilepsy. Medications included

Seroquel 200 mg at hs, Zoloft 100 mg at hs, Zonagra 200 mg at hs (for control of seizures), and Concerta 54 mg each morning. This medication program has not been changed in the except for a slight dose increase of Seroquel and addition of a midday dose of Ritalin, on February 25th. Physical examination and neuropsychological testing were essentially within normal limits with full scale IQ of 103, except for evidence of defective inhibition and of impulsivity. There is EEG evidence of isolated segments of aberrant reactivity in the right temporal region. In the opinion of the neuropsychologist, these results do suggest a neurobehavioral etiology to the patient's history of mood and behavioral problems, particularly his aggression.

The patient's course of treatment in the has featured frequent behavioral problems with limit testing, frequently needing redirection, especially early on. After the 4<sup>th</sup> week the problem behaviors are becoming less frequent. However there don't seem to be positive things emerging; even into the 5<sup>th</sup> week he was demonstrating minimal work in school and minimal motivation in treatment.

The patient's history strongly suggests that the suicide of his father was a major stressor, and coincided with the emergence of behavior problems. The family session on 2/8/07 featured enmeshment and unclear boundaries between mother and patient; he was able to tell her that she babies him; after the session mother was noted to be in tears. It is not clear that these two very significant issues have been receiving sufficient attention in treatment: the patient's feelings about father's suicide, and mother's apparent vulnerability - being easily hurt or upset, and her difficulty being a firm parent.

There is no note in the record of any trial visits off campus. There is no note addressing mother's readiness or ability to deal with the patient at home. It is not clear that family sessions have been as frequent as they might be. It is not clear that attention is being given to preparing patient and mother for his return home. Having said that, if at this time the patient were discharged from the and returned to live with mother, with his behavioral problems only beginning to come under precarious control and without more progress in mother's difficulty dealing effectively with patient's behavior; it is quite likely he would regress to escalating behavior problems again, and lose the precarious progress he has made.

Therefore, it is the determination of this reviewer that the denial be overturned from 2.16.07-3.2.07 as it is deemed medically necessary. It would be suggested that the staff of the treating facility be advised that special attention may need to be given in subsequent reviews to how well the following two apparently very significant issues are being addressed in the treatment: a) the patient's feelings about his father's suicide, and b) the mother's apparent vulnerability and difficulty being a firm parent.

**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

**XX 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)