



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 01/11/08

**IRO CASE #:**

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

Adolescent residential treatment program from 03/13/06 to 11/29/06.

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

Diplomate of the American Board of Pain Medicine  
Diplomate of the American Board of Psychiatry & Neurology in Psychiatry  
Diplomate of the American Board of Quality Assurance & Utilization Review  
American Society of Addiction Medicine  
TDI-DWC ADL Level II  
TDI-DWC Designated Doctor  
TDI-DWC Maximum Medical Improvement & Impairment Rating Doctor

**REVIEW OUTCOME**

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

Overtured

Primary Diagnosis Code	Services Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Upheld/Overtured
31389	Residential Treatment Services	N/A	Concurrent	N/A	03/13/06-11/30/06	Overtured

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- 06/26/00 thru 07/06.99 –Hospital, 35 pages.
- 03/17/02 thru 07/15/03 –School District evaluation reports, 14 pages.
- 05/27/03 –Ph.D., 8 pages.

4. 03/13/06 thru 11/13/06 –200 pages.
5. 09/16/06 –retrospective review, 3 pages.
6. 09/20/06 –denial, 4 pages.
7. 10/08/07 –4 pages.
8. 12/11/07 – Request for IRO/TDI information, 11 pages.
9. Appeal documentation, 11 pages.

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

The patient has a long-standing psychiatric history with well documented infant abuse history. She has had significant long-standing emotional and developmental problems. The patient has been in psychotherapy since she was six years old. She had a two week inpatient admission. She has had extensive psychiatric and developmental therapies. She has decompensated on psychiatric medications in the past. She has significant comorbid intelligence problems. The patient's acute deterioration in her functioning generalized across multiple cognitive behavioral domains. She had extensive assaultive behavior. Social inadequacy, intellectual inadequacy, and inability to process her own feelings.

Residential treatment provided structure, medications, interaction with peers, within the context of documented infant abuse, with persistent borderline intellectual functioning. The patient had been in individual psychotherapy since she was six years old without resolution of these problems.

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

The documentation supported the need for residential level of care during this timeframe.

Authorize residential treatment for 03/13/06 to 11/29/06. The patient had been in lower levels of care for approximately nine years with persistent developmental, intellectual, and emotional deficits. Given the history of infantile abuse, as well as borderline intellectual functioning, the clinical likelihood of internalizing a more stable psychic structure in the standard thirty to sixty day residential treatment or ongoing weekly office-based regimen is highly unlikely. This is evidenced by the documentation showing some significant improvements in various areas during the residential treatment timeframe but also persistent significant deficits at discharge in December of 2006.

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

Nationally recognized CIGNA behavioral health guidelines. The CIGNA Behavioral Health Level of Care guidelines incorporate the American Psychiatric Association's clinical practice guidelines. Available at

<http://www.cignabehavioral.com/web/basicsite/provider/pdf/levelOfCareGuidelines.pdf>

Accessed 01/10/08.

Salient features from above criteria relative to this review:

#### Guidelines for Admission

1. All basic elements of medical necessity must be met. AND
2. (Either A or B, plus both C and D must be met)

A. There exists a pervasive and/or severe psychiatric disorder that has failed to respond to all available and appropriate outpatient interventions (including: intensive outpatient treatment, partial hospitalization, group home).

B. A reasonable course of active treatment in an acute care setting has resulted in an acceptable degree of stability — However, the stability achieved continues to require around-the-clock supervision by mental health treatment staff in a structured setting.

C. The participant and/or family demonstrate chronic dysfunction, which may respond to multimodal therapeutic and systemic interventions, and all parties commit to active regular treatment participation.

D. The participant is able to function with some independence and participate in structured activities that will assist in developing the skills necessary for functioning outside of the controlled psychiatric environment.

#### Guidelines for Continued Stay

(All of the following must be met)

1. The participant continues to meet all basic elements of medical necessity.
2. The participant (and family as appropriate) has participated in the development of an individualized treatment plan, which includes consideration of all applicable and appropriate treatment modalities (Bio-Psycho-Social approach), realistic and achievable treatment goals, and a discharge plan with specific timelines for expected implementation and completion. Despite active participation by the participant, the treatment plan implemented has not led to enough improvement in the participant's condition such that he/she

cannot yet safely move to and sustain improvement in a less restrictive level of care as evidenced by:

- The participant continues to suffer from symptoms and/or behaviors that led to this admission; OR
- The participant has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. The participant and family continue to participate in active weekly face-to-face (or an approved alternate schedule) family therapy. Multi family group is not a substitute for individual family therapy.