

# Applied Resolutions LLC

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 18, 2008

**IRO CASE #:**

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

Inpatient treatment starting 2/18/08

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

M.D., Board Certified by American Board of Psychiatry and Neurology with added qualifications in Child and Adolescent Psychiatry; Licensed to Practice Medicine in the State of Texas

### **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)

Upon independent review the reviewer finds that the inpatient treatment as of 2/18/08 to present is not medically necessary.

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

Adverse Determination Letters, 2/21/08, 2/22/08

Nursing Record, 4/7/08  
Letter to IRO, 5/2/08  
Dr. Daily Notes, 2/18/08-4/7/08  
Treatment Records, 2/22/08-3/31/08  
Physician's Orders, 2/18/08-3/31/08  
Chronology of Events, undated  
2008 Hospitalization, Psychiatric, Adult, Criteria (from insurance carrier)  
MD, 2/21/08  
MA, LPC, 3/19/08

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

Patient is a female with longstanding symptoms of depression and anxiety. Symptoms included decreased appetite, weight loss of 15 pounds, withdrawal and isolative behavior, insomnia, fatigue, decreased energy, feelings of worthlessness, impaired concentration. She exhibited excessive worry. She denied hallucinations, delusions, or paranoia. She had some suicidal ideation but no plans or attempts. She had been treated with many different antidepressants, as well as Emsam patch and Seroquel. She attended IOP in June xxxx at Hospital. There is no history of substance abuse. She lives at home with her husband but her marriage is not strong. She was admitted for treatment on 2/18/2008. The insurance company reviewer denied treatment as of 2/18/2008 based on lack of medical necessity. The reason for the decision was: "She has no suicidal/homicidal psychosis. Is not documented as a risk to herself or to others. She has support. Other levels of care are available. In patient level of care appears to exceed the intensity of service necessary for her treatment. She does need medication changes and supportive/psychotherapy more intense than available at outpatient level of care. Partial hospitalization treatment meets the criteria for medical necessity and the member may choose partial hospitalization treatment. "

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

Upon review of the provided medical records and relevant guidelines this reviewer finds that the inpatient treatment starting 2/18/08 is not medically necessary. The provided documentation does not reveal any evidence of homicidal or suicidal ideation at admission, no evidence of hallucinations or delusions, and no major medical problems requiring inpatient level of care. The patient is cooperative and desirous of help. The patient has been treated in outpatient therapy and IOP but has never been in a partial hospital setting. For these reasons I concur with the reviewing physician that her symptoms would be appropriately treated at the partial hospital level of care and uphold the determination.

### **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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)