



# MedHealth Review, Inc.

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Amended Report 4/22/13

## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 4/22/13

**IRO CASE #:**

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

The item in dispute is the concurrent medical necessity of continued MH residential treatment (RTC) level of care from 2/22/13 to 3/24/13.

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

The reviewer is a Medical Doctor who is board certified in Psychiatry. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the concurrent medical necessity of continued MH residential treatment (RTC) level of care from 2/22/13 to 2/28/13.

The reviewer agrees with the previous adverse determination regarding the concurrent medical necessity of continued MH residential treatment (RTC) level of care from 3/1/13 to 3/24/13.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**  
**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a xx year of age, single male who was admitted on 01/15/2013, after a recent Acute IP care, and treated for MDD, GAD and r/o PTSD from 01/15/2013 – 03/21/2013. His stay @ RTC was authorized from 01/15/2013 thru 02/21/2013 as medically necessary and the stay between 02/22/2013 thru 03/21/2013 was denied as medically not necessary. This Utilization review has been requested to determine the medical necessity of continued RTC stay between 02/22/2013 thru 03/21/2013.

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

Based on the above information, the reviewer disagrees with review and his denial of RTC stay of this patient beyond 02/22/2013. The reviewer believes that continued RTC stay beyond 02/22/13 was medically necessary due to attending physician Xxxx, MD reporting of persistent depression, social isolation, disturbed sleep, erratic eating pattern and continued weight loss.

The rationale for denying continued RTC stay was based on the fact that the patient was not Psychotic, acutely suicidal or homicidal and was medically stable with no adverse reactions to medications. Presence of any or all of these criteria would have mandated Acute Inpatient admission with 24/7 medical/psychiatric monitoring. Absence of these acute crisis may mandate denial of Acute IP-LOC and not RTC-LOC. Discharging on 02/22/13 for PHP –LOC would have increased his risk of treatment failure and/or repeat de-compensation because (i) unstable home environment (ii) nearest PHP center is about one hour away in rural Pennsylvania and (iii) the patient is minor and cannot drive self to PHP. Therefore continued RTC stay of this patient from 02/22/2013 thru 02/28/2013 is medically necessary based upon the records provided by the parties to the review.

The reviewer's rationale for Non- Authorization of continued RTC stay (03/01/2013 thru 03/24/2013) is as follows: Additional RTC stay beyond 02/28/2013 can only be determined based review of additional progress reports

and practical plan of disposition/aftercare. The reviewer notes that there were no such notes for his review during the dates in question. Therefore, this portion of the request must be found not medically necessary due to a lack of documentation.

**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) DSM IV-TR - American Psychiatric Association publication.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION) Milliman U/R criteria