

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Continued inpatient services, 12/31/09-1/4/10

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

MD, Certified by the American Board of Psychiatry and Neurology with additional qualifications in Child and Adolescent Psychiatry

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/4/10, 1/5/10
Integrated Mental Health Notes, 12/30/09
12/10/09-1/4/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male admitted to RTC level of care on xx/xx/xx. The patient had a history of failed outpatient treatment since July 2009. He had a history of blackouts from alcohol. He would not speak to therapists or counselors and ran away from school and refused outpatient treatment. He was arrested on 12/8/2009 and charged with possession and running away. He apparently smoked marijuana twice weekly. He was admitted to RTC with diagnoses of cannabis dependence, alcohol abuse and ODD. Notes indicate he did make some progress and had successful individual and family therapy sessions on 12/22/2009 and 12/24/2009.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

There is nothing in the material from the most recent treatment sessions to justify the need for RTC level of care. The record does not meet TACADA criteria for continued stay. There was no report of significant withdrawal, the patient was medically stable, and was not reported as being an imminent danger to himself or others. This reviewer agrees with the

previous reviewers that the patient could be treated safely and effectively in a less restrictive setting. Therefore, the reviewer finds that medical necessity does not exist for Continued inpatient services, 12/31/09-1/4/10.

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

ACOEM-AMERICA 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)