

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Dental Work: CPT Codes D2950, D2750, D3330, D3320

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

DDS, 18 years in private practice
Knowledge of endodontics and crown and bridge restoration of teeth

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for dental Work: CPT Codes D2950, D2750, D3330, D3320.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/11/08, 7/25/08
Carrier Submission, 8/4/08
ODG Guidelines and Treatment Guidelines
Records, 4/1/08-4/18/08
, 4/1/08
, MD, 4/28/08
, MD, 4/30/08
, MD, , MD, , LPT, Concentra

, DO, 6/10/08
, 6/11/08-7/17/08
MD, 7/2/08
, MD, 7/15/08
, DC, 5/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee fell from a communications tower construction site, landing on the right side of his face. He had fractures of the right eyelid and nasal lacerations and left humeral head fracture. His right femur was fractured and he suffered a concussion. The extraoral exam and intraoral exam regarding the employee's dentition were unremarkable. The injured employee was hospitalized for two weeks.

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

The reviewer finds that medical necessity does not exist for dental Work: CPT Codes D2950, D2750, D3330, D3320. There was not sufficient evidence provided in the medical records reviewed to support the requested treatment. Indeed, there was nothing in the records which demonstrates that the procedures that are being requested are related or a result of the injury that was suffered by this claimant.

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)**