



**INDEPENDENT REVIEW INCORPORATED**

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Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 08/04/09

**IRO CASE #:**

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

Custom implant metal ceramic retainer of teeth #9 and #11 as well as porcelain fused to high noble metal on tooth #10

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.D.S., M.D., Oral and Maxillofacial Surgery

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
872.72	D6069		Prosp.	1					Upheld

**INFORMATION PROVIDED FOR REVIEW:**

- Case assignment.
- Letters of denial and case reviews 04/13, 4/14 & 5/26/09.
- Treating doctor's correspondence and views of mouth.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee was involved in a work-related accident on xx/xx/xx. The injured employee required complex oral rehabilitation with full coverage crowns on fractured teeth #6, 7, 8, 9, 10, and 11. The injured patient's oral rehabilitation was apparently completed on 07/15/04. It was determined that the injured employee would need a custom implant metal ceramic retainer on teeth #9 and #11 as well as a Pontic, which is a porcelain fused to high noble metal on tooth #10.

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

I have reviewed all the records presented before me and have come to the conclusion in that at this time there is no documentation provided that would indicate the current need for a custom implant metal ceramic retainer on teeth #9 and #11 as well as a Pontic on tooth #10. Based on my medical judgment and experience, as well as Official Disability Guidelines, I do not believe that this proposed treatment is medically necessary, and as such, I uphold the denial for services.

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

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- 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 judgment, 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 national accepted medical literature (provide a description).
  - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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