MCMC

IRO Medical Dispute Resolution M2 Prospective Medical Necessity
IRO Decision Notification Letter

Date: 1/24/2005
Injured Employee:
MDR #: M2-05-0547-01
TWCC #:
MCMC Certification #: 5294

DETERMINATION: Approved

Requested Services:
Please address prospective medical necessity of the proposed right shoulder arthroscopic subacromial decompression and labral repair, regarding the above mentioned injured worker.

MCMC llc (MCMC) is an Independent Review Organization (IRO) that has been selected by The Texas Workers' Compensation Commission (TWCC) to render a recommendation regarding the medical necessity of the above requested service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M2 Prospective Medical Dispute Resolution on 12/22/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The right shoulder arthroscopic subacromial decompression and labral repair is medically reasonable and necessary for treatment of the work injury.

This decision is based on:

- TWCC Notification of IRO Assignment dated 12/22/04
- TWCC MR-117 dated 12/22/04
- TWCC-60 stamped received 12/7/04 3 pgs
- Genex Services Non Authorization Recommendation dated 11/1/04 2 pgs; Reconsideration Decision dated 11/5/04 2 pgs
- El Paso Orthopaedic Surgery Group & Center for Sports Medicine: History and Physical dated 12/21/04 3 pgs
- TWCC 73s dated 12/21/04, 11/24/04, 11/10/04, 11/3/04, 10/27/04, 9/29/04, 9/1/04
- Dr. D, Subsequent Medical Report dated 11/29/2004 2 pgs, 11/03/2004 3 pgs, 11/10/2004 2 pgs, 10/27/2004 2 pgs, 9/29/2004 2 pgs, 9/1/2004 2 pgs
- Texas Imaging Services of El Paso, MRI of the Cervical Spine dated 11/1/04, MRI of the right shoulder dated 11/1/04

This is a 47-year-old male who sustained a sudden traction injury to his right shoulder on ___, when attempting to stop himself from falling with his outstretched arm. He has continued to work and has also received conservative care, without resolution of his symptoms. The MRI scan of 11/01/2004 reveals: "Superior labral tear (SLAPType II) with a cyst at the posterior margin of the superior labrum consistent with a paralabral cyst."

Based on the mechanism of injury, symptoms, physical examination, and MRI findings, this injured individual has a symptomatic superior labral tear (shoulder). His symptoms are not expected to resolve without surgical treatment. The first denial was based on the lack of an MRI, which has since been accomplished, and is positive, showing a cystic change consistent with a superior labral tear. The second denial is based on the suggestion that activity modification and further therapy will likely resolve the injury, with which I disagree based on cited literature reference. The second denial also considers the MRI finding of a labral cyst as incidental. Again, I disagree based on the cited literature, which indicates that the finding of a cyst indicates high certainty of a symptomatic labral tear, which will require surgical treatment.

REFERENCE:

Mileski, RA and Snyder, SJ "Superior Labral Lesions in the Shoulder: Pathoanatomy and Surgical Management." JAAOS Vol 6 No 2: March/April 1998 pp. 121-131.

This reference summarizes the diagnosis, etiology, imaging findings, treatment options for this array of lesions, commonly noted as SLAP. Traction to the shoulder, such as when attempting to stop a fall, is a common mechanism producing this injury.

The symptoms mimic impingement or instability. Examination findings vary. MRI may or may not reveal the lesion, but a paralabral cyst is a finding with high certainty for associated tear. Nonsurgical treatment is not successful. Arthroscopic surgery for decompression and repair is indicated.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

The reviewing provider is a (Licensed/Boarded) (Specialty) and certifies that no known conflict of interest exists between the reviewing (Specialty) and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO.

Your Right to Request A Hearing

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (ten) days or your receipt of this decision (28Tex.Admin. Code 142.5©.)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28Tex.Admin. Code 148.3©.)

This decision is deemed received by you 5 (five) days after it was mailed (28Tex.Admin. Code 102.4(h**)(2)** or 102.5(d)). A request for a hearing **and a copy of this decision** should be sent to:

Chief Clerk of Proceedings / Appeals Clerk
Texas Workers' Compensation commission
P.O. Box 17787
Austin, Texas, 78744
Fax: 512-804-4011

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U. S. Postal Service from the office of the IRO on this

__24__ day of _____January_____ 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee:_____