MEDICAL CONTESTED CASE HEARING NO. 09220
M6-09-20034-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on July 29, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that right shoulder arthroscopy, rotator cuff repair, debridement and acromioplasty is not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was represented by JBT, attorney.
Respondent/Carrier appeared and was represented by JSW, attorney.

BACKGROUND INFORMATION

Claimant sustained bilateral shoulder injuries on _____, while trying to keep from running over the drunken driver that had pulled in front of him. After the accident, Claimant sought medical care at (Healthcare Provider) for bilateral shoulder pain, left greater than right. He was treated, given a sling for his left arm, and released. He subsequently received care at (Healthcare Provider 2) (Healthcare Provider 2) for a bilateral shoulder strain. His last visit at (Healthcare Provider 2) was on May 21, 2008. At that time, he reported that his right shoulder was worse than his left and characterized the right shoulder pain as a constant dull pain. The physician's assistant noted that he had very mild tenderness to palpation over the right anterior glenohumeral joint with full range of motion bilaterally, negative Hawkin's, negative Neer's, negative drop arm, negative crank, negative Obrien's, and negative apprehension tests. In light of his improvement, he was released to full duty and no further visits were scheduled.

On October 24, 2008, Claimant sought additional care from Dr. H, DC (Dr. H) at (Rehabilitation Center) in (City), Texas. Dr. H noted that Claimant complained of bilateral shoulder pain with a pain scale rating of 8 on the right and 2 on the left. Dr. H ordered an MRI that was done on January 28, 2009. The MRI report indicates a partial tear of the supraspinatus tendon, acromioclavicular joint osteoarthritis and subacromial spurring, and minimal subacromial subdeltoid bursitis on the right. Dr. H then referred Claimant to Dr. M, MD (Dr. M) in (City), Texas, for an orthopedic consult. Dr. M saw Claimant on February 18, 2009, and immediately recommended arthroscopic surgery, tentatively scheduling the surgery for March 30, 2009.

Dr. M requested preauthorization for a right shoulder arthroscopy, rotator cuff repair, debridement and acromioplasty. Carrier denied preauthorization, citing the *Official Disability Guidelines* (ODG). Claimant requested reconsideration of the request and, on May 6, 2009, it

was again denied. Claimant then requested that the Texas Department of Insurance appoint an IRO to review the request. On May 26, 2009, (Independent Review Organization), Inc., the IRO appointed by the Department, upheld Carrier's denial of the right shoulder surgery. The IRO physician reviewer, a board certified orthopedic surgeon, found that the medical records provided did not indicate extensive conservative care, injections, or active rehabilitation and very little supervised physical therapy. The physician reviewer based his concurrence with Carrier's denial on the ODG. Claimant has appealed the IRO's determination.

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (Texas Labor Code §408.021). "Health care reasonably required" is defined as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, generally accepted standards of medical practice recognized in the medical community (Texas Labor Code §401.011(22-a)). "Evidence based medicine" means the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines (Texas Labor Code §401.011 (18-a)). In accordance with the above statutory guidance, Rule 137.100 directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be reasonably required. Thus, the focus of any health care dispute starts with the health care set out in the ODG. With regard to the requested procedures, the ODG provides as follows:

ARTHROSCOPY

Definition: An arthroscope is a tool like a camera that allows the physician to see the inside of a joint, and the surgeon is sometimes able to perform surgery through an arthroscope, which makes recovery faster and easier. For the Shoulder, see Surgery and Diagnostic arthroscopy.

SURGERY FOR ROTATOR CUFF REPAIR

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic

decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)

Revision rotator cuff repair: The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001)

ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS

3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.
(Washington, 2002)

ACROMIOPLASTY

See Surgery for impingement syndrome

SURGERY FOR IMPINGEMENT SYNDROME

Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007) Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007) A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an

intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009)

ODG Indications for Surgery™ -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS

3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

In support of his contention that the IRO decision is incorrect, Dr. M testified that the ODG are only guidelines and do not establish the parameters of definitive care. He testified that the statistics recited in the ODG regarding the need for surgery for rotator cuff injuries are contradicted by articles published in the Orthopedic Knowledge Update Shoulder and Elbow (Issues 1 and 2). He testified that the articles, published by the American Academy of Orthopedic Surgeons, state that 80% of partial thickness rotator cuff tears worsen without surgical intervention, 10% remain the same, and 10% heal. Dr. M did not provide evidence that would tend to show that the surgical criteria in the ODG were met at the time he requested preauthorization for surgery, at the time Carrier's utilization review agents and IRO evaluated the request for preauthorization. It is separately noted that neither the articles from the Orthopedic Knowledge Update nor the studies, if any, were offered into evidence.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See* Black vs. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999); E.I. Du Pont De Nemours and Company, Inc. v. Robinson, 923 S.W.2d 549 (Tex. 1995). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. Black v. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999). Dr. M is qualified to offer his opinion on the medical necessity of the requested arthroscopy, rotator cuff repair, debridement and acromioplasty. The literature cited by Dr. M in support of his opinion is, however, unsubstantiated and is of little weight. Without information regarding the quality of the scientific and medical evidence upon which his opinion is based or the age of those studies and medical evidence, Dr. M's opinion is unsupported by evidence based medicine. Claimant also testified in this matter, but his testimony and that of Dr. M, unsupported by evidence based medicine, are insufficient to overcome the IRO decision.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. Claimant sustained a compensable injury on _____, while the employee of (Employer).

   C. (Independent Review Organization), Inc. was appointed as the IRO in this matter by the Texas Department of Insurance.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant failed to show that he meets the criteria under the ODG for either arthroscopic surgery to the rotator cuff or acromioplasty.

4. The debridement recommended by Dr. M was not shown to be a reasonably necessary procedure.

5. Arthroscopy, rotator cuff repair, debridement and acromioplasty is not reasonably required medical treatment for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that arthroscopy, rotator cuff repair, debridement and acromioplasty is not reasonably required medical care for the compensable injury of _____.

DECISION

Claimant is not entitled to arthroscopy, rotator cuff repair, debridement and acromioplasty for the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701.

Signed this 30th day of July, 2009.

KENNETH A. HUCHTON
Hearing Officer