MEDICAL CONTESTED CASE HEARING NO. 10047
M6-09-21300-01

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 medical contested case hearing was held on September 17, 2009 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (hereinafter "IRO") that the Claimant / Petitioner is not entitled to open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 for the compensable injury of _____?

PARTIES PRESENT

The Claimant/Petitioner appeared and was assisted by EA, ombudsman. The Carrier/Respondent appeared and was represented by CA, attorney.

BACKGROUND INFORMATION

The Claimant / Petitioner injured her left shoulder on _____. She was prescribed physical therapy and injections, but did not improve. A MRI revealed an interstitchal partial thickness tear of the subscapularis. On March 31, 2009, Dr. H, M.D., performed an arthroscopy of the left shoulder with debridement of the partial tear of the rotator cuff, excision of subacromial bursa and acromioplasty. Dr. H noted improvement after the surgery of March 31, 2009. However, on June 2, 2009, Dr. H recommended a repeat MRI of the left shoulder due to the Claimant / Petitioner's complaints. The June 9, 2009 MRI of the left shoulder disclosed mild tendinopathy and bursal side fraying of the supraspinatus tendon, moderate osteoarthritic changes in the acromioclavicular joint, mild effusion within the subacromial and subdeltoid bursa and no evidence of any muscle atrophic changes. Thereafter, a request was made for an open repair of the rotator cuff to the left shoulder and acromioplasty to the left shoulder to include CPT code # 23420. Such requested treatment underwent utilization review and was denied. Reconsideration was requested and such reconsideration was denied. The Claimant / Petitioner then appealed the denials to an IRO and the IRO reviewer upheld the previous adverse determinations. Consequently, the Claimant / Petitioner appealed the IRO decision and is the reason for the present discussion and decision.

DISCUSSION

Medical Necessity

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. TEX. LAB. 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, then generally accepted standards of medical practice recognized in the medical community. TEX. LAB. CODE § 401.011 (22a). Health care under the Texas Workers' Compensation system must be consistent with evidence-based medicine if that evidence is available. "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. TEX. LAB. CODE § 401.011 (18a).

In accordance with the above statutory guidance, the Division has adopted treatment guidelines by rule. 28 Tex. Admin. Code § 137.100 (Division Rule 137.100). This Rule directs health care providers to provide treatment in accordance with the current edition of the *Official Disability Guidelines* (hereinafter "ODG") and that such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG.

The pertinent provisions of the ODG applicable to this case are as follows, to wit:

> **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)

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 randomized 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.
(Washington, 2002)

In the instant case, both parties relied on the ODG in support of their respective positions for or against the requested treatment. When both parties cite the ODG in support of their respective positions, such positions must be supported by sufficient medical evidence to justify application of the ODG in the manner promulgated. Both of the utilization review doctors denied the requested treatment and the IRO reviewer upheld the denial of the requested treatment citing to relevant provisions of the ODG. Specifically, there was mention of discrepancies in the clinical examinations of the examining doctor which called into question the source of the Claimant's complaints of pain. *See* ODG, *supra*. As such, the IRO reviewer who is board certified in orthopedic surgery reviewed the records and upheld the adverse determinations of the utilization review doctors. Essentially, the IRO reviewer cited the ODG and opined that because of the conflicting clinical evidence obtained as a result of the physical examinations and the recent MRI findings, the requested treatment could not be approved. Thereafter, the IRO reviewer cited the ODG in upholding the denials of the requested treatment.

When weighing expert testimony, the hearing officer must first determine whether the doctor rendering an expert opinion is qualified to offer such. In addition, the hearing officer must determine whether the opinion is relevant to the issues at bar and whether it is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* *Black v. Food Lion, Inc.*, 171 F.3d 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. *See* *Black*, 171 F.3d 308. In determining reliability of the evidence, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. *Kelly v. State*, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990) *aff'd*, 824 S.W.2d 568 (Tex. Crim. App. 1992).

Additionally, "[a] decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal." *See* Division Rule 133.208 (t). "In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence." *Id*. Accordingly, the Claimant / Petitioner, as the party appealing the IRO decision, has the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. In this case, sufficient evidence-based medical evidence to justify application of the ODG in the manner promulgated was lacking. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that the Claimant / Petitioner is not entitled to open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 for the compensable injury of _____.

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. On _____, Claimant was the employee of (Employer).

   C. On _____, Claimant sustained a compensable injury.

   D. The IRO determined that the Claimant is not entitled to open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 for the compensable injury of _____.

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

3. The IRO determined that the open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 was not reasonable and necessary health care services for the compensable injury of _____.

4. Open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 is not health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, does not have 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 the IRO that open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 is not health care reasonably required for the compensable injury of _____.

DECISION

The Claimant / Petitioner is not entitled to open repair of rotator cuff left shoulder and acromioplasty left shoulder to include CPT code # 23420 for the compensable injury of _____.

ORDER

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

The true corporate name of the insurance carrier is **TWIN CITY FIRE 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 18th day of September, 2009.

Julio Gomez, Jr.
Hearing Officer