MEDICAL CONTESTED CASE HEARING NO 12019
M6-11-34577-01

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 September 19, 2011 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to an arthroscopic subacromial decompression of the right shoulder for his compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant appeared, and was assisted by Ombudsman BO; Self-insured appeared, and was represented by Attorney ST.

BACKGROUND INFORMATION

Claimant tripped and fell backward on the date indicated, injuring his low back and right shoulder. He described the course of his symptoms and treatment, indicating that despite conservative treatment and injections to the injured shoulder, he continues to experience pain, including pain at night. Claimant is aware of the potential risks of surgery, and wishes to proceed with the recommended procedure.

Dr. T, M.D., an orthopedic surgeon retained by Self-insured, testified that although Claimant meets three of the four surgical criteria set forth in the ODG, Claimant's MRI study not only fails to document evidence of impingement, it negates the presence of impingement.

DISCUSSION

Texas Labor Code Section 408.021 provides that 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. Health care reasonably required is further defined in Texas Labor Code Section 401.011(22-a) 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. Health care under the Texas Workers'

Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011(18-a) to be 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. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, and outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable. Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and 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. Also, in accordance with Division Rule 133.308(t), "[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. 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."

With regard to the proposed surgery, the ODG states as follows:

> 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) A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. (Ketola, 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)

As noted above, the ODG lists four criteria that must be satisfied in order for surgery to be recommended. Although the evidence does indicate that Claimant meets the first three specified indications for surgery, he has not met the fourth, which requires evidence of a gadolinium MRI,

ultrasound, or arthrogram showing positive evidence of impingement. Not only does the record of the Contested Case Hearing contain no evidence that Claimant has undergone an ultrasound or arthrogram of his injured right shoulder, but the report of Claimant's August 18, 2010 MRI study does not show that it was a gadolinium MRI, as contemplated by the ODG. Since Claimant did not undergo the type of MRI study required, it is unnecessary to discuss the differing medical interpretations of that study. To the contrary, it need only be observed that Claimant does not meet the ODG criteria for the recommended surgery and that Claimant has offered no evidence-based medical evidence to contradict the determination of the IRO; therefore, a decision in favor of Self-insured is appropriate as to the issue presented.

Even though all the evidence presented may not have been discussed in detail, it was considered; the Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. On (Date of Injury), Claimant was employed by (Self-Insured), Employer.

2. On (Date of Injury), Employer was self-insured for workers' compensation purposes.

3. On (Date of Injury), Claimant's residence was located within seventy-five miles of the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

4. Self-insured delivered to Claimant a single document stating the true corporate name of Self-insured, and the name and street address of Self-insured's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 1.

5. On (Date of Injury), Claimant sustained damage or harm to the physical structure of his body while he was within the course and scope of his employment with Employer.

6. The injury referenced in the previous Finding of Fact arose out of Claimant's employment with Employer.

7. Claimant's surgeon recommended that Claimant undergo an arthroscopic subacromial decompression of the right shoulder as reasonable and necessary treatment for the shoulder component of Claimant's compensable injury of (Date of Injury).

8. The IRO determined that an arthroscopic subacromial decompression of the right shoulder is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

9. An arthroscopic subacromial decompression of the right shoulder is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

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-based medical evidence is not contrary to the decision of the Independent Review Organization that an arthroscopic subacromial decompression of the right shoulder is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to an arthroscopic subacromial decompression of the right shoulder for his compensable injury of (Date of Injury).

ORDER

Self-insured 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 self-insured is **(SELF-INSURED),** and the name and address of its registered agent for service of process is:

(SELF-INSURED)
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 20th day of September, 2011.

Ellen Vannah
Hearing Officer