

MEDICAL CONTESTED CASE HEARING NO 12088  
M6-12-37206-01

**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 March 7, 2012 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a right shoulder arthroscopy with superior labrum anterior posterior (SLAP) repair and exploration of subacromial decompression and 1 assistant surgeon for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Petitioner/Claimant appeared and was represented by TP, attorney.  
Respondent/Carrier appeared and was represented by STS, attorney.  
Petitioner/Provider, Dr. KB, appeared as a witness in this matter.

**BACKGROUND INFORMATION**

The Claimant sustained a compensable injury to the right shoulder for which he underwent a right shoulder arthroscopy with subacromial decompression and debridement of a partial cuff tear on June 21, 2010. Subsequently, the Claimant underwent physical therapy from July 8, 2010 through September 15, 2010. Due to ongoing pain, the Claimant sought medical treatment with Dr. KB on or about June 2, 2011. The Claimant underwent a right shoulder arthrogram on August 18, 2011 and on or about August 30, 2011 Dr. B requested the disputed procedures. A utilization review agent (URA) reviewed the request and denied the requested procedures. Upon reconsideration with another URA, the request was again denied. An orthopedic surgeon on behalf of the Independent Review Organization (IRO) reviewed the request along with the URA's decision on reconsideration and upheld the URA's decision, which denied the requested procedures. The various reasons cited for denial of the requested procedures include failure of the medical report to objectively document exhaustion of conservative treatment such as activity modification, home exercise training, oral pharmacotherapy, injections, pain scales, physical therapy notes and lack of progress. There was no objective evidence that the Claimant was unlikely to gain clinically significant functional response from continued treatment and less invasive modalities, which were not fully exhausted. The Claimant underwent a functional capacity evaluation (FCE), which reflected an ability to function at a heavy physical demand

level and the arthrogram which the Claimant underwent revealed findings of osteoarthritis with some residual tendinosis without evidence of a labral tear.

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 (22a) 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 (18a) 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 in making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, 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 in accordance with 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 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 (sic) 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."

**The ODG defines Arthroscopy as:**

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.

Diagnostic arthroscopy

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally

determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

#### SLAP lesion diagnosis

Recommend criteria below, and the use of shoulder arthroscopy. When the glenoid labrum becomes injured or torn, it is described as a labral tear. These tears may be classified by the position of the tear in relation to the glenoid (which is often called the “shoulder socket”). A SLAP tear is a tear in the labrum that covers the top part of the shoulder socket from front to back (Superior Labral tear from Anterior to Posterior). A SLAP tear occurs at the point where the long head of biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm. SLAP lesions have proven difficult to diagnose clinically. This study concluded that SLAP-specific physical examination results cannot be used as the sole basis of a diagnosis of a SLAP lesion. (Jones, 2007) Pathology of the SLAP lesion poses a significant challenge to the rehabilitation specialist due to the complex nature and wide variety of etiological factors associated with these lesions. (Wilk, 2005) SLAP lesions are becoming a more recognized cause of shoulder pain and disability. The diagnosis of these lesions is difficult due to vague symptoms and a high degree of overlap with other shoulder disorders, and this requires a high index of suspicion. Advances in MR arthrography may lead to advances in preoperative diagnosis of labral tears, but definitive diagnosis, classification, and management is greatly facilitated with the use of the shoulder arthroscopy. (Maurer, 2003) In a systematic review of studies evaluating 15 clinical tests for labral pathology against MRI or surgery, six accurate tests were identified from high quality studies: Biceps Load I, Biceps Load II, Internal Rotation Resistance (IRRT), Crank, Kim, and Jerk tests. (Munro, 2009) This systematic review concluded that there are no good physical examination tests for effectively diagnosing superior labrum anterior posterior (SLAP) shoulder tears, and special tests for SLAP tears are clinically limited and invalid. (Calvert, 2009) See also Surgery for SLAP lesions.

#### Criteria for Classification of SLAP lesions:

- *Type I*: Fraying and degeneration of the superior labrum, normal biceps (no detachment); Most common type of SLAP tear (75% of SLAP tears); Often associated with rotator cuff tears; These may be treated with debridement.

- *Type II*: Detachment of superior labrum and biceps insertion from the supraglenoid tubercle; When traction is applied to the biceps, the labrum arches away from the glenoid; Typically the superior and middle glenohumeral ligaments are unstable; May resemble a normal variant (Buford complex); Three subtypes: based on detachment of labrum involved anterior aspect of labrum alone, the posterior aspect alone, or both aspects; Posterior labrum tears may be caused by impingement of the cuff against the labrum with the arm in the abducted and externally rotated position; Type-II lesions in patients older than 40 years of age are associated with a supraspinatus tear whereas in patients younger than 40 years are associated with participation in overhead sports and a Bankart lesion; Treatment involves anatomic arthroscopic repair.

- *Type III*: Bucket handle type tear; Biceps anchor is intact.

- *Type IV*: Vertical tear (bucket-handle tear) of the superior labrum, which extends into biceps (intrasubstance tear); May be treated with biceps tenodesis if more than 50% of the tendon is involved.

(Wheless, 2007)

Surgery for SLAP lesions:

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. (Nam, 2003) (Pujol, 2006) (Wheless, 2007).

Regarding surgery for impingement syndrome and acromioplasty:

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).

Dr. B testified that he did not request conservative treatment as he believed that this request would have been denied and the Claimant had undergone physical therapy after his last surgery. He noted that although the arthrogram did not have clear findings of a labral tear, due to his experience and the described symptoms and pain from the Claimant, he has a strong clinical suspicion that a labral tear is the condition from which the Claimant suffers. When asked, Dr. B stated that perhaps the Claimant's range of motion (ROM) would not become greater after the procedure, but it would alleviate the pain created during movement within that range of motion. The ODG does state that diagnosis of SLAP lesions are a challenge and require a high index of suspicion. Here, in addition to the reasons cited for denial by the URAs and the IRO, the arthrogram did not support a finding of a SLAP lesion and the FCE revealed a highly functional individual for which the proposed procedure would not result in an increase in his ROM. Regarding the subacromial decompression request, the Claimant failed to document and meet the required criteria of conservative care and objective evidence that the Claimant is likely to gain clinically significant functional response. Regarding the utilization of the use of an assistant during the requested procedures, neither the ODG nor Dr. B addressed this issue.

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 (Date of Injury), Claimant was the employee of (Employer), Employer and sustained a compensable injury.
  - C. On (Date of Injury), Employer provided workers' compensation insurance coverage with New Hampshire Insurance Company.
  - D. The IRO upheld the denial of the requested procedures.
2. Carrier delivered to Claimant and Provider 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. The Petitioner failed to present evidence-based medical evidence contrary to the decision of the IRO that the Claimant is not entitled to the requested procedures.
4. A right shoulder arthroscopy with superior labrum anterior posterior (SLAP) repair and exploration of subacromial decompression and 1 assistant surgeon is not health care reasonably required for the 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 is not contrary to the decision of the IRO that a right shoulder arthroscopy with superior labrum anterior posterior (SLAP) repair and exploration of subacromial decompression and 1 assistant surgeon is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

Claimant is not entitled to a right shoulder arthroscopy with superior labrum anterior posterior (SLAP) repair and exploration of subacromial decompression and 1 assistant surgeon for the compensable injury of (Date of Injury).

### **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 **NEW HAMPSHIRE INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CORPORATION SERVICE COMPANY  
211 EAST 7TH STREET, SUITE 620  
AUSTIN, TEXAS 78701-3218**

Signed this 8th day of March, 2012.

Virginia Rodriguez Gomez  
Hearing Officer