MEDICAL CONTESTED CASE HEARING NO. 14002

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.

ISSUE

A contested case hearing was held on September 4, 2013, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to limited arthroscopic surgical debridement of the left shoulder for the compensable injury on (Date of Injury)?

PARTIES PRESENT

The petitioner/claimant appeared and was assisted by TM, ombudsman. The carrier/respondent appeared and was represented by RJ, attorney.

BACKGROUND INFORMATION

The claimant sustained his left shoulder injury in a motor vehicle accident in (Date of Injury). After the claimant failed conservative care, including injections and physical therapy, JS, M.D. performed the first surgery on the claimant's left shoulder in January, 2011. The surgery included subacromial decompression, distal clavicle excision, and rotator cuff repair.

A left shoulder MRI performed in February, 2011, after the surgery, was compared to the MRI taken prior to the surgery. The February MRI report noted that, "There continues to be signal within the supraspinatus tendon, consistent with a mild intra substance tearing, as well as some new or additional superior surface tearing in the lateral aspect of the rotator cuff."

Although with post-surgical physical therapy the claimant regained essentially full range of motion and strength in his left arm, the pain in his left arm, after initially subsiding to some degree, worsened. Dr. S gave the claimant an injection in his left shoulder in June, 2011 which provided no relief, and by August, 2011 was considering another arthroscopic surgical procedure. Dr. S had another left shoulder MRI performed in August, 2011 which revealed a mild partial-thickness bursal surface tear of the anterior aspect of the supraspinatus tendon. In an August, 2011 examination record, Dr. S acknowledged that the claimant had "obviously had some type of setback" but that he was unsure why the claimant was having ongoing and persistent pain in his left shoulder.

The claimant began to treat with RR, D.O. who referred the claimant to LD, M.D., an orthopedic surgeon, who began seeing the claimant at the end of 2011. Based on the claimant's ongoing severe pain, Dr. D performed a revision surgery on the claimant's left shoulder in February, 2012. The surgical procedures performed by Dr. D included acromioplasty, distal clavicle resection, subacromial adhesiolysis, and labral debridement. Dr. D reported that the claimant's pain decreased 50% from its pre-surgery level. In the weeks following the surgery, the claimant again regained full range of motion, but the claimant's pain did not further improve from the 50% reduction experienced immediately following the surgery. A left shoulder arthrogram MRI ordered by Dr. R in February, 2013 showed a mild partial thickness articular surface tear of the supraspinatus tendon as had the prior MRIs.

In contemplating future treatment that could provide the claimant additional relief from his still substantial left shoulder pain, Dr. D, in a December, 2012 examination note, acknowledged that because the claimant "has had a couple of operations, I think trying to resolve his residual discomfort is a bit problematic." Dr. D then proposed to use injections which would have a potential therapeutic but also diagnostic value to identify the location of the pain source, whether subacromial adhesions or an intraarticular problem like adhesions in the rotator interval. Based on the results from the injection in January, 2013, Dr. D requested authorization to perform a third arthroscopic surgery, which would include lateral coracoid decompression and subacromial adhesiolysis.

In reviewing Dr. D's request for limited arthroscopic surgical debridement of the left shoulder, the first utilization review doctor, AD, M.D.(Dr. D (2)), an orthopedic surgeon, who also testified at the hearing, opined that the surgery was not reasonable care in this case. He stated, and testified, that the "minimal partial thickness cuff tear" shown by the MR arthrogram was "consistent with post-op changes due to the 2 prior cuff repairs." He pointed out that the claimant had no loss of range of motion or strength, that the arthrogram showed nothing uncommon or unusual, including no coricoid impingement, and that with each additional revision surgery there were increasing possibilities for infection, atrophy, and CRPS. Dr. D (2) did not believe that a third surgery in three years was supported by the objective evidence.

The utilization review doctor, an orthopedic surgeon, who reviewed the request on reconsideration also believed the proposed third surgery was not reasonable or necessary medical care under the circumstances. He based his opinion on his observations that the imaging only showed a "minimal partial thickness cuff tear that would be consistent with post-op changes due to the 2 prior cuff repairs," and that the claimant had full motion and strength in his shoulder with "discomfort." In addition, the reviewer noted that the injection by Dr. D had provided temporary relief, and that, by the time the reviewer performed his review, there was no recent record of an examination, physical therapy, or other non-surgical treatment as recommended by the Official Disability Guidelines (ODG).

An IRO reviewer, identified as a Board Certified orthopedic surgeon, upheld the carrier's denial of the treatment requested. As had the prior reviewers, the IRO reviewer focused on the full range of motion and lack of weakness in the claimant's left shoulder, and imaging studies of "only a partial-thickness rotator cuff tear, which certainly could be consistent with two previous shoulder surgeries." The reviewer saw no ongoing evidence for impingement in the imaging studies.

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 (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. 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 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 (s), "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."

On the date of this medical contested case hearing, the ODG provides the following with regard to the limited arthroscopic surgical debridement of the left shoulder contemplated in this case:

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) 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)

Surgery for adhesive capsulitis

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. (Dudkiewicz, 2004) (Guler-Uysal, 2004) (Castellarin, 2004) (Berghs, 2004) Study results support the use of physical therapy and injections for patients with adhesive capsulitis. (Pajareya, 2004) (Carette, 2003) (Arslan, 2001) The latest UK Health Technology Assessment on management of frozen shoulder concludes that arthrographic distension (also called hydrodilatation), which involves controlled dilatation of the joint capsule under local anaesthetic with sterile saline or other solution such as local anaesthetic or steroid, guided by radiological imaging (arthrography), needs more study. There is insufficient evidence to draw conclusions about the efficacy of distension (arthrographic or non-arthrographic) for frozen shoulder. In conclusion, few studies of distension were identified and only single studies of different comparisons were available. Based on one study of satisfactory quality there is a little evidence of potential benefit with distension compared with placebo. In conclusion, although the evidence available suggested potential benefit from capsular release, these studies were at high risk of bias and cannot be used to draw conclusions regarding the efficacy of this treatment for frozen shoulder. (Maund, 2012)

Dr. D provided a relatively extensive explanation letter to support his assertion that a "decompression of [the claimant's] lateral coracoid space, through coracoplasty and adhesiolysis, has a high likelihood of significantly improving [the claimant's] shoulder." Dr. D pointed out that it was the second of the claimant's two surgeries, the procedure performed by Dr. D, that provided significant, although not complete, relief to the claimant. Dr. D asserted that this was a "complicated" case, involving a "pretty uncommon injury" of a "longitudinal split in the supraspinatus tendon laterally that did not appear to be avulsed from bone." Dr. D discussed how MRIs do not always reveal all pathology so that he additionally used a "symptom elimination test" to supplement the findings of the MRIs. For that test, he "performed an injection of the interval between the humeral head and the coracoid, which alleviated [the claimant's] symptoms as long as the anesthetic was functional." Dr. D addressed the Guidelines in the ODG by maintaining that they did not address this case because they "tend to be best applied to previously unoperated individuals to eliminate extreme degrees of inappropriate surgical recommendation. . . . Guidelines are the antithesis of customization. Proper medical care depends upon customization, particularly in complicated cases such as this." Dr. D further asserted that "the orthopedic literature does not address how to deal with this specific spectrum of pathology in this specific set of circumstances." Of all of the medical opinions in the record, it is the doctors who have examined and had contact with the claimant who believe that further surgical intervention is appropriate and necessary.

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. As an orthopedic surgeon, the claimant's treating doctor is qualified to offer an opinion on his treatment. 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).

In addition, the ODG Guidelines themselves note that the treatment planning set out in the Guidelines are presented as an ideal case plan, indicating selected interventions recommended for each visit, along with timing for these visits. The Treatment Planning section is designed only as a recommendation. The Treatment Planning section is NOT meant to be used as a rigid protocol or rule applied in all cases.

. . .

> Healthcare providers may choose to follow the Treatment Planning section at their own discretion. They may also consider interventions outside of the Treatment Planning section. . . . A payor should not use the absence of a particular therapy from the Treatment Planning section as a basis to deny care.

Dr. D provided an extensive explanation of what further treatment he believes is reasonably necessary to provide the claimant relief from his significant ongoing left shoulder pain. Dr. D provided an explanation of why he believes the treatment is necessary, his clinical basis for recommending that treatment, and the specific reasons why he does not believe, in this case, the ODG Guidelines are applicable. Dr. D's prior procedure did provide the claimant with substantial although not complete relief. The claimant has had two prior surgeries, the first of which, by another doctor, provided little or no relief. That the claimant has had "multiple" prior surgeries, as the term was used by the reviewing doctors, is not really an accurate description of the claimant's medical history over the past almost three years in connection with his left shoulder.

Based on a careful review of the evidence presented in the hearing, the claimant met his burden of overcoming the IRO decision by a preponderance of the evidence.

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 Workers' Compensation Division of the Texas Department of Insurance.

   B. On (Date of Injury), the claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), the claimant sustained a compensable injury.

   D. On (Date of Injury), the employer provided workers' compensation insurance with Wausau Underwriters Insurance Company, Carrier.

   E. The IRO determined that the claimant is not entitled to limited arthroscopic surgical debridement of the left shoulder.

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

3. Limited arthroscopic surgical debridement of the left shoulder is health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

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

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

3. The preponderance of the evidence is contrary to the decision of the IRO that limited arthroscopic surgical debridement of the left shoulder is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

The claimant is entitled to limited arthroscopic surgical debridement of the left shoulder for the compensable injury on (Date of Injury).

ORDER

The carrier is liable for the benefits at issue in this hearing. The claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **WAUSAU UNDERWRITERS 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, TX 78701-3232

Signed this 11th day of September, 2013.

William M. Routon II
Hearing Officer