

MEDICAL CONTESTED CASE HEARING NO. 15033

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the claimant is not entitled to a right shoulder arthroscopy for the compensable injury of (Date of Injury).

**STATEMENT OF THE CASE**

A contested case hearing was held on March 3, 2015 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a right shoulder arthroscopy, for the compensable injury of (Date of Injury)

**PARTIES PRESENT**

Petitioner/Claimant appeared and was assisted by DV, ombudsman.  
Respondent/Carrier appeared and was represented by BJ, attorney.

**DISCUSSION**

The claimant's doctor requested preauthorization for a right shoulder arthroscopy in order to repair a torn rotator cuff. The carrier denied the request twice, and the claimant's doctor appealed. An Independent Review Organization (IRO) was appointed to settle the dispute. The IRO determined that the requested surgery was not medically indicated or appropriate. The IRO decision indicates that a board-certified orthopedic surgeon conducted the review for the IRO. The decision also indicates that the orthopedic surgeon relied in part on the treatment portion of the Official Disability Guidelines (ODG) in conducting the review.

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."

With regard to a right shoulder arthroscopy to repair a torn rotator cuff, under Shoulder: "Surgery for rotator cuff repair," the ODG reads as follows:

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)

*Recent research:* Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of five studies comparing surgical and nonsurgical management favored operative repair, but the

evidence was too limited to make conclusions regarding comparative effectiveness. 113 studies comparing various operations found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no difference in health-related quality of life, function, pain, range of motion, and strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers' compensation status, and duration of symptoms usually did not predict poorer outcomes. (Seida, 2010) "Rotator cuff surgery is a viable option for many patients, but, as with any surgery, it is not for everybody," said AHRQ Director Carolyn M. Clancy, M.D. "This report has good news: most interventions work, and each patient should talk to his or her doctor about which to option to pursue." Most older patients who suffer a rotator cuff tear are first treated with up to 3 months of nonsurgical treatment such as pain and anti-inflammatory medications, exercise, and rest. If treatments other than surgery do not work, the rotator cuff may be repaired surgically, using a variety of methods ranging from minimally invasive techniques to an open operation. Patients can then undergo rehabilitation to restore their range of motion, muscle strength, and function following surgery. Rotator cuff tears also can occur in younger adults, usually as a result of traumatic injury. In such cases they are almost always treated with surgery. Some doctors have maintained that earlier surgery results in less pain and better use of the shoulder, leading to an earlier return to work and decreased costs; so, patients often face the difficult decision of opting for surgery rather than waiting for nonoperative treatments to work. However, researchers found little evidence that earlier surgery benefits patients. Comparative Effectiveness of Nonoperative and Operative Treatments for Rotator Cuff Tears is the newest comparative effectiveness report from the AHRQ's Effective Health Care Program. The Effective Health Care Program represents the leading federal

effort to compare alternative treatments for health conditions and make the findings public, to help doctors, nurses, pharmacists and others work together with patients to choose the most effective treatments. (Clancy, 2010) This prospective cohort study concluded that PT is effective for most patients with atraumatic full-thickness rotator cuff tears and shoulder pain, without the need for surgery. At six weeks fewer than 10% of patients had decided to undergo surgery, and after 2 years, only 2% of the rest had opted for surgery. Patients did most of their physical therapy at home and usually made only 1 weekly visit to the physical therapist. (Kuhn, 2011) One-third of rotator cuff repairs fail, and 74% of the failures occur within three months of surgery. Healed tendons, or recurrent tears, at six months can predict outcomes at seven years. (Kluger, 2011) Not surprisingly, larger tears are harder to repair, and the retear rate based on rotator cuff tear size is: 10% for  $\leq 2$  cm<sup>2</sup>; 16% for 2–4 cm<sup>2</sup>; 31% for 4–6 cm<sup>2</sup>; 50% for 6–8 cm<sup>2</sup>; & 57% for  $>8$  cm<sup>2</sup>. (Murrell, 2012) There is insufficient evidence to suggest efficacy in operative or nonoperative treatment of rotator cuff tears in patients aged older than 60 years. (Downie, 2012) In this RCT, full-thickness rotator cuff repair outcomes were the same, with or without acromioplasty. Acromioplasty is commonly performed during arthroscopic rotator cuff repair, but it does not improve outcomes by 2-year follow-up. (Abrams, 2014)

### **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)

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

To overcome an IRO decision which denies treatment, a claimant must do **one** of the following:

- (1) Show that the requested treatment is consistent with the criteria set out by the Official Disability Guidelines (ODG);
- (2) Present evidence-based medicine that is more persuasive than the ODG. In other words, a claimant must present documentation or testimony that is based on evidence-based medicine. That documentation or testimony must show that the requested treatment is likely to be effective; or
- (3) Show that the requested treatment is not addressed by the ODG. In such a case, a claimant must show that the requested treatment is supported by other evidence-based medicine, or if there is no evidence-based medicine on point, a claimant must show that the requested treatment meets the generally accepted standards of medical practice recognized in the medical community.

In the instant case, the claimant asserted that the requested treatment was consistent with the criteria set out by the ODG. To support his assertion, the claimant presented a report dated January 29, 2015 from HE, M.D. That report, however, does not explain how the requested treatment is consistent with the specific criteria set out by the ODG.

RFH, D.O., a board-certified orthopedic surgeon, testified on behalf of the carrier. He explained in detail why the requested treatment was not consistent with ODG criteria. Dr. H was credible and persuasive.

The credible evidence did not establish that a right shoulder arthroscopy is health care reasonably required for the compensable injury.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

### **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), the Claimant was the employee of (Employer), Employer.
  - C. On (Date of Injury), the Claimant sustained a compensable injury.
  - D. The IRO determined that the claimant should not have the requested treatment.
2. Carrier delivered to Petitioner/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. The requested treatment is not consistent with the criteria set out by the ODG.
4. A right shoulder arthroscopy 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 is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

Claimant is not entitled to a right shoulder arthroscopy 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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**RICHARD J. GERGASKO  
TEXAS MUTUAL INSURANCE COMPANY  
6210 EAST HIGHWAY 290  
AUSTIN, TEXAS 78723**

Signed this 13<sup>th</sup> day of March, 2015

Carlos Cerrato  
Hearing Officer