MEDICAL CONTESTED CASE HEARING NO. 16052

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence-based medical evidence is not contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to a left shoulder arthroscopic biceps tenodesis for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on January 19, 2017, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to a left shoulder arthroscopic biceps tenodesis for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant (hereinafter referred to as Claimant) appeared and was assisted by SA, ombudsman. Respondent/Carrier (hereinafter referred to as Carrier) appeared and was represented by BJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: RGM

For Carrier: None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 and HO-2

Claimant's Exhibits C-1 through C-3

Carrier's Exhibits CR-A through CR-I

DISCUSSION

Claimant is a master carpenter with Employer and sustained compensable bilateral shoulder injuries on (Date of Injury), when he lost his footing as he was coming down from an attic. He was able to catch himself with his hands, then dropped to the ground. After initial conservative treatment failed to provide lasting relief, an MRI revealed the presence of a biceps tear in Claimant's left arm. Claimant underwent rotator cuff surgery on November 17, 2015, but continues to have left shoulder pain. A request for preauthorization of the requested left shoulder biceps tenodesis was submitted to Carrier. After a review by Carrier's utilization review agent, the request was denied. It was again denied on reconsideration and the provisions for independent review were invoked. The Texas Department of Insurance selected Clear Resolutions as the IRO. Clear Resolutions assigned the review to a physician reviewer who is Board certified in orthopedic surgery. On December 2, 2016, Clear Resolutions issued its Notice of Independent Review Decision, advising the parties that it recommended that Carrier's denial be upheld. Claimant then invoked the Division's dispute resolution process in accordance with the Act and the Rules.

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 for the care of an individual patient. 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. The focus of any health care dispute starts with the health care set out in the

ODG. 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. (Division Rule 133.308 (s).)

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. 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. *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). Evidence is considered in terms of the general acceptance of the theory and technique by the relevant scientific community; the expert's qualifications; the existence of literature supporting or rejecting the theory; the technique's potential rate of error; the availability of other experts to test and evaluate the technique; and 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). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *Black v. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999).

The IRO physician reviewer's report noted that the requested tenodesis was not approved by the first utilization review agent because there were marginal findings on the MRI and no clear clinical indication that repeat left shoulder surgery was appropriate. He also noted that the procedure had been again denied by the second utilization review agent "as there was no clinical documentation regarding the degree of a SLAP lesion on the prior MRI study" and it was "also unclear what course of physical therapy was completed following surgery." The physician reviewer also noted that guidelines do not recommend biceps tenodesis for patients above the age of 40 with a concomitant rotator cuff repair. Claimant is (Age) years of age. The physician reviewer wrote that it was unclear whether the absence of the biceps tendon was due to an interval tear or a previous biceps tenodesis procedure, that Claimant's most recent physical examination findings noted a positive O'Brien sign, the medical records did not discuss failure of conservative management since surgery in 2015, and the records did not address the utilization review agent's concerns. Citing the ODG and his medical judgment, clinical experience and expertise, he concluded that the denial of the requested left shoulder tenodesis should be upheld.

With regard to biceps tenodesis, the ODG provides the following:

> Surgery for biceps tenodesis
>
> Recommended as an option for type II or type IV SLAP lesions in patients over 40 years of age. See SLAP lesion diagnosis. Biceps tenodesis (suture of the end of the tendon to the bone) is a surgical procedure usually performed for the treatment of refractory biceps tendonitis of the shoulder. A biceps tenodesis may be

performed as an isolated procedure, or part of a larger shoulder surgery such as a rotator cuff repair. Patients with biceps tendon problems may have a detachment of the biceps tendon from the socket of the shoulder (a SLAP tear), or they may have inflammation and irritation of the biceps tendon itself. A biceps tenodesis is usually performed in patients over the age of 40, whereas other procedures such as a SLAP repair may be attempted in younger patients. Individuals older than 35 years with an isolated type II SLAP lesion had a shorter postoperative recovery, a more predictable functional outcome, and a higher rate of satisfaction and return to activity with biceps tenodesis compared with a biceps repair. Based on these observations, biceps tenodesis is preferable to biceps repair for isolated type II SLAP lesions in non-overhead athletes older than 35 years. (Denard, 2014) Surgical repair remains the gold standard for most type II and type IV SLAP lesions that fail nonoperative management. However, more recently reported data has demonstrated unacceptably high failure rates with primary repair of type II SLAP lesions. Biceps tenodesis may offer an acceptable, if not better, alternative to primary repair of SLAP lesions. This study adds to the evolving literature supporting biceps tenodesis as a viable treatment for type II and IV SLAP lesions. (Gottschalk, 2014) Successful arthroscopic repair of symptomatic superior labral tears in young athletes has been well documented. Superior labral repair in patients older than 40 years is controversial, with concerns for residual postoperative pain, stiffness, and higher rates of revision surgery. While studies show that good outcomes can be obtained with SLAP repair in an older cohort of patients, age over 40 and workers' compensation status are independent risk factors for increased surgical complications. The cumulative evidence supports labral debridement or biceps tenotomy over labral repair when an associated rotator cuff injury is present. (Erickson, 2014) Biceps tenodesis is a viable treatment option for SLAP repair. (Huri, 2014) Practice trends indicate that the proportion of SLAP repairs has decreased over time, with an increase in biceps tenodesis and tenotomy. Increased patient age correlates with the likelihood of treatment with biceps tenodesis or tenotomy versus SLAP repair. For patients with isolated SLAP lesions, the proportion of SLAP repairs decreased from 69.3% to 44.8%, while biceps tenodesis increased from 1.9% to 18.8%, and biceps tenotomy increased from 0.4% to 1.7%. For patients undergoing concomitant rotator cuff repair, SLAP repair decreased from 60.2% to 15.3%, while biceps tenodesis or tenotomy increased from 6.0% to 28.0%. There was a significant difference in the mean age of patients undergoing SLAP repair (37.1 years) versus biceps tenodesis (47.2 years) versus biceps tenotomy (55.7 years). (Patterson, 2014) See also Surgery for SLAP lesions.

Criteria for Surgery for Biceps tenodesis:

- History and physical examinations and imaging indicate significant biceps tendon pathology
- After 3 months of failed conservative treatment (NSAIDs, injection and PT)
- Advanced biceps tendinopathy
- Type II SLAP lesions (fraying and some detachment)
- Type IV SLAP lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear)
- Generally, type I and type III SLAP lesions do not need any treatment
- Also patients undergoing concomitant rotator cuff repair
- Age 40 and older
- Below age 40 if undergoing concomitant rotator cuff repair

Claimant offered a letter from his surgeon, TM, M.D., that urged approval of the request for tenodesis. Dr. M's letter did not address the ODG, did not address the type of SLAP lesion involved, and did not tend to show that Claimant is an outlier whose condition should not be treated within the recommendations of the ODG. Carrier offered a report from BS, M.D., who is also an orthopedic surgeon. Dr. S concurred with the utilization review agents and IRO physician reviewer in finding that the requested left shoulder tenodesis is not medically necessary for the compensable injury. After consideration of all of the evidence presented, the Hearing Officer finds that the preponderance of the evidence-based medical evidence is not contrary to the IRO determination that a left shoulder arthroscopic biceps tenodesis is not health care reasonably required for the compensable injury of (Date of 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 as follows:

   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.

   C. On (Date of Injury), Employer provided workers' compensation insurance through Carrier.

   D. Claimant sustained a compensable bilateral shoulder injury on (Date of Injury).

E. The Texas Department of Insurance appointed Clear Resolutions as the Independent Review Organization to review Carrier's denial of preauthorization for the requested left shoulder arthroscopic biceps tenodesis.

F. The Independent Review Organization upheld Carrier's denial of preauthorization.

2. Carrier delivered to 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. There is evidence-based medical evidence set forth in the ODG addressing arthroscopic biceps tenodesis of the shoulder.

4. The IRO physician reviewer determined that there was insufficient medical documentation of the grade of the SLAP lesion, conservative management and other factors to warrant approval of the requested left shoulder arthroscopic biceps tenodesis.

5. The preponderance of the evidence-based medical evidence is not contrary to the IRO's determination that the requested left shoulder arthroscopic biceps tenodesis 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. Left shoulder arthroscopic biceps tenodesis is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to left shoulder arthroscopic biceps tenodesis 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 Section 408.021.

The true corporate name of the insurance carrier is **CARRIER**, and the name and address of its registered agent for service of process is

RICHARD GERGASKO, PRESIDENT
6210 EAST HWY. 290
AUSTIN, TEXAS 78723

Signed this 26th day of January, 2017.

KENNETH A. HUCHTON
Hearing Officer