MEDICAL CONTESTED CASE HEARING NO. 09168
M6-09-18324-01

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.

ISSUE

A benefit contested case hearing was held on May 14, 2009, 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 outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by SB, ombudsman. Carrier appeared and was represented by attorney, DP.

BACKGROUND INFORMATION

Claimant sustained a compensable injury to his right shoulder. As a result of that injury, on March 4, 2008, he underwent arthroscopic rotator cuff repair, distal clavicle resection and bursectomy with acromioplasty. Claimant testified that the surgery did not help his condition and he has had continuing pain and loss of range of motion since the surgery.

The post-surgical medical records show that Claimant underwent physical therapy after surgery and experienced some increased range of motion. In August of 2008, his treating doctor noted that despite his surgery, he continued to have significant weakness and loss of function in his right arm. He noted that Claimant had finished physical therapy and had profound weakness with stressing of the rotator cuff.

Claimant saw Dr. S, a different orthopedic surgeon, on June 3, 2008. Dr. S noted Claimant's prior surgery and continued pain with limited range of motion. He diagnosed a re-tear or continued tear of the right rotator cuff with impingement as well as C5-6 stenosis with EMG evidence of C6 radiculopathy and right cubital and carpal tunnel syndromes. He ordered a right shoulder MR arthrogram to rule out the tear and an injection at C5-6 as well as possible cervical surgery.

The MR arthrogram (with and without contrast) was limited due to patient motion, but the radiologist suspected a partial thickness tear of the distal supraspinatus tendon, extending from the humeral attachment proximally in a laminar configuration in the distal critical zone.

Following the arthrogram, Dr. S discussed both cervical and shoulder surgery with Claimant, and sought preauthorization for right shoulder acromioplasty and distal clavicle resection with rotator cuff repair.

Four utilization reviewers denied Dr. S's request for preauthorization of the requested surgical procedure. All four reviewers cited the *Official Disability Guidelines (ODG)* in their analysis of the request.

In July of 2008, the first reviewer, an orthopedic surgeon, noted the prior surgery four months earlier, and denied the requested surgery due to a lack of evidence of failed conservative care and doubts about the accuracy of the MR arthrogram.

In late October, another reviewer, also an orthopedic surgeon, denied preauthorization for the requested surgery citing a lack of evidence that physical therapy and injections had been tried and the fact that the imaging studies did not provide a clear rationale for repeating the same surgery.

On December 15, 2008, a third reviewer, a general surgeon, also determined that the requested surgery was not medically necessary. He noted the evidence of C6 radiculopathy and a lack of documentation of treatment or exclusion of the cervical spine as the pain generator.

On reconsideration, a fourth reviewer, also an orthopedic surgeon, denied the requested treatment. He stated that the rationale for surgery was not adequately outlined. He noted a lack of evidence of nocturnal symptoms or a positive impingement test. He further stated that he would need to know whether a subacromial injection resulted in short-term benefit thereby revealing a positive impingement test. He also cited the overlaying cervical problems in his rationale for denying the requested surgery.

An IRO reviewer, an orthopedic surgeon, upheld the carrier's denial of the requested surgical procedure. The IRO reviewer stated that the relationship of the C6 radiculopathy to the shoulder complaints had not been documented. The reviewer stated that the medical records did not support or explain the need for a repeat of the same procedure performed a year earlier. The reviewer concluded, per the *ODG*, that Claimant was not an appropriate candidate for the repeat surgery.

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

"Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG),* and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. The *ODG* allows for the requested surgical procedure and sets out the circumstances under which such treatment is recommended as reasonable and necessary.

The *ODG* Treatment Guidelines for shoulder acromioplasty refer the reader to "surgery for impingement syndrome," which the *ODG* discuss 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)

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)

The *ODG* discuss surgery for rotator cuff repair 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)

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)

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

The orthopedic surgeon IRO reviewer denied the requested procedure citing the relevant provisions of the *ODG*, specifically the fact that the medical records did not rule out the C6 radiculopathy as the cause of the shoulder complaints; and the lack of support in the medical records to support the repeat procedure. Claimant also relied on the *ODG* in disputing the IRO opinion and claimed that the requested surgical procedure was not identical to the first surgery; the imaging studies provided sufficient evidence of a partial thickness tear of the rotator cuff; the C6 radiculopathy had been treated with injections and was not the pain generator; and, all conservative measures had been exhausted.

When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. Mere citation to the *ODG* does not carry the day. In the instant case, the IRO report is specific and concludes that Claimant fails to meet the criteria set out in the *ODG*.

The *ODG* contemplate shoulder surgery for impingement syndrome and rotator cuff tear only when certain criteria have been met, specifically conservative care (including cortisone injections) for three to six months; pain with active arc motion and pain at night; weak or absent abduction and positive impingement sign with temporary relief of pain with anesthetic injection; AND imaging findings including x-rays AND MRI, ultrasound or arthrogram with positive evidence of deficit in the rotator cuff. For revision rotator cuff repair, the patient must also meet additional criteria. Under the *ODG*, all of the criteria must be met to justify medical necessity of the contemplated shoulder surgery.

Claimant's requesting orthopedic surgeon, Dr. S, testified that the requested surgery meets the *ODG* criteria and referenced his medical records in support of his testimony. Carrier offered testimony from Dr. C, a board certified orthopedic surgeon, who opined that Dr. S's records did not provide sufficient evidence that the criteria set out in the *ODG* had been met. Specifically, Dr. C, testified that there were no x-rays in the medical records and no record of the impingement test required by the *ODG*; nor, was there any evidence that steroid injections in the shoulder had been administered. Further, he questioned the accuracy of the MR arthrogram due to motion artifact.

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. 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). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and

(7) 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).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. The treatment proposed by Dr. S is a departure from the *ODG* in that the Dr. S's treatment records and notes do not show that the required *ODG* criteria for the requested surgical procedures have been met. As an orthopedic surgeon, Dr. S is certainly qualified to render an opinion regarding shoulder surgery. His opinion, however, without supporting documentation in his medical records of x-rays; positive evidence of impingement on the arthrogram; failed conservative treatment including shoulder injections; and, failed impingement test, does not constitute evidence-based medicine justifying departure from the *ODG*, nor does it meet the requisite evidentiary standard required to overcome the IRO.

The preponderance of the evidence is not contrary to the IRO decision and the requested outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair does not meet the criteria set out in the *ODG*.

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 _____, Claimant was the employee of (Employer), when he sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

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

3. Claimant's orthopedic surgeon recommended outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair for treatment of Claimant's compensable shoulder injury.

4. For treatment of the shoulder, the *ODG* sets out the circumstances under which acromioplasty and rotator cuff repair surgeries are recommended.

5. Claimant's medical records do not show that Claimant meets the *ODG* criteria for the requested surgical procedures.

6. The IRO decision upheld the Carrier's denial of the requested outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair because the requested service did not meet the criteria set out in the *ODG*.

7. The requested service is not consistent with the *ODG* criteria for outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair.

8. The requested outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair is not health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

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

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

3. The preponderance of the evidence is not contrary to the decision of IRO that outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to outpatient right shoulder acromioplasty/distal clavicle resection and rotator cuff repair for the compensable injury of _____.

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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RUSSELL OLIVER, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 21st day of May, 2009.

Erika Copeland
Hearing Officer