MEDICAL CONTESTED CASE HEARING NO. 18005

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 Administrative Law Judge determines that the claimant is not entitled to a right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair for the compensable injury on (Date of Injury), but the claimant is entitled to right shoulder arthroscopy with subacromial decompression only for the compensable injury on (Date of Injury).

ISSUE

On February 8, 2018, William M. Routon II, a Division administrative law judge, held a medical contested case hearing 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 a right shoulder arthroscopy with subacromial decompression or a right shoulder arthroscopy with subacromial decompression, and distal clavicle excision debridement of the rotator cuff or rotator cuff repair for the compensable injury on (Date of Injury)?

PARTIES PRESENT

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

BACKGROUND INFORMATION

The issue as presented to the IRO envisions two procedure requests. The first is simply a right shoulder arthroscopy procedure to effect a subacromial decompression. The second would include not only the subacromial decompression but would also involve a distal clavicle excision debridement of the rotator cuff or a direct rotator cuff repair.

The first procedure was apparently approved at some point by the carrier's utilization reviewers. But the claimant's surgeon, GI, M.D., evidently believed that the full second procedure was justified in this case. It was the second procedure request that the IRO focused on in determining medical reasonableness and necessity for both requests. While the claimant met most of the requirements for rotator cuff repair in the Official Disability Guidelines (ODG), the requirement cited by the utilization reviewers and the IRO doctor, all of whom were identified as orthopedic

surgeons, was that the MRI of the claimant's right shoulder revealed a large partial-thickness or a small full-thickness rotator cuff tendon tear, neither of which, it was asserted, would support the requested distal clavicle excision debridement of the rotator cuff or a direct rotator cuff repair. The reviewers stated that the ODG only supported surgery for a moderate to severe full-thickness tear. Even though the IRO reviewer believed "there continued to be evidence to support the right shoulder arthroscopic subacromial decompression . . . procedure," the entire procedure, as considered by the IRO, was denied since the rotator cuff repair portion of the procedure was not supported by the ODG. In addition to the nature of the rotator cuff tear as partial-thickness as opposed to full-thickness, the IRO reviewer noted that the right shoulder MRI "did not reveal any posttraumatic changes of the acromioclavicular (AC) joint or severe degenerative joint disease of the acromioclavicular joint."

The carrier presented the testimony of BS, M.D., who performed a peer review in this case. Dr. S was in agreement with the IRO decision that the MRI did not show any posttraumatic changes in the AC joint and no separation in the joint. He noted that no bone scan had been performed to show an AC joint separation. Dr. S agreed that the partial-thickness tear did not support rotator cuff surgery based on the requirements of the ODG. Dr. S did testify, however, that the first of the two procedure requests presented to the IRO, the right shoulder arthroscopy with subacromial decompression, was a reasonable procedure based on the medical records in this case and the ODG.

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 shoulder arthroscopy with subacromial decompression:

> Not recommended as an isolated procedure since best-evidence regarding long-term clinical outcomes for surgery has consistently been no better than conservative treatment for subacromial impingement syndrome (SIS), rotator cuff tendinopathies, or in association with rotator cuff tears. While subacromial decompression (SAD) has been historically encouraged, 20-30% long-term failure rates have been recently reported, being especially poor for worker's compensation claimants. When pre-authorization is considered beyond these guidelines based on specific individual patient considerations, especially with other treatable shoulder pathology, then simple bursectomy/debridement is currently favored over acromioplasty. See *contingent indications* below.
>
> See also *Surgery for rotator cuff repair*.
>
> ***ODG Indications for Surgery*™ -- Bursectomy/Debridement and/or Acromioplasty:**
>
> **Criteria** for subacromial decompression for subacromial impingement syndrome (80% improve without surgery.) Not recommended as an isolated procedure.
>
> 1. **Conservative Care:** Recommend at least 1 year unless meets earlier surgical criteria for other associated shoulder diagnoses: *Physical therapy combined with home exercise*, NSAIDs, corticosteroid injection, and taping are beneficial. Treatment must be directed toward gaining full motion with stretching and strengthening to re-balance shoulder musculature. PLUS
> 2. **Subjective Clinical Findings:** Significant functional impairment persisting at least 1 year. AND Pain with active arc motion between 90-130 degrees. AND Pain at night. PLUS

3. **Objective Clinical Findings:** Tenderness over rotator cuff or anterior acromial area. AND Positive impingement signs. 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 MRI, ultrasound, or arthrogram shows positive evidence of impingement (subacromial bursitis, rotator cuff tendinosis, Type II or III acromion).

Risk vs. benefit: Surgery for subacromial impingement syndrome (SIS) has gradually fallen out of favor over the past decade due to questionable efficacy and higher than previously understood failure rates. Acromioplasty offers no additional benefit during rotator cuff repair, adding potential increased morbidity. Pain reduction has not been significantly reduced following surgery for SIS, and over half fail to regain normal shoulder function or active range-of-motion. Failure of isolated subacromial decompression (SAD) occurs in 21-29%, with poor outcomes being even higher for worker's compensation claimants, calcific tendonitis, deep partial thickness rotator cuff tears, and with clavicular co-planning. Since multiple systematic reviews and meta-analyses have demonstrated equivalent results with or without surgery for SIS, risk generally exceeds benefit for surgical treatment.

Historical research: Surgery for subacromial impingement syndrome (SIS) has historically included arthroscopic subacromial decompression (SAD, acromioplasty), but has never been indicated for patients with mild symptoms or without limitation of activities. Conservative care including cortisone injection(s) and an exercise program has typically been carried out for at least three to six months prior to any surgical consideration. The diagnosis of SIS is on the early continuum with other rotator cuff degenerative conditions including rotator cuff syndrome and rotator cuff tendonitis/tears. (*Prochazka, 2001*) (*Ejnisman-Cochrane, 2004*) (*Grant, 2004*) Arthroscopic SAD does not appear to change functional outcomes following arthroscopic rotator cuff repair. (*Gartsman, 2004*) A systematic review (SR) of 4 randomized controlled trials (RCT) comparing arthroscopic with open acromioplasty could not detect any appreciable differences for all measures including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, or return to work. (*Barfield, 2007*) Operative treatment, including distal clavicle resection and/or SAD (with or without rotator cuff repair), might be considered for patients not improving after 6 months of conservative therapy, and for patients age under 60 with debilitating symptoms impairing function. Conservative treatment outcomes vary, with persistent or worsening symptoms historically reported for 30-40%. More severe symptoms, longer duration, and a hook-shaped (Type II or III) acromion tend to

do less well. (*Hambly, 2007*) A prospective RCT compared arthroscopic subacromial *bursectomy* alone with *SAD+bursectomy* for primary SIS without rotator cuff tear, failing conservative treatment. At 2.5 years both groups showed good clinical results with no statistically significant differences. The authors concluded that SIS is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (*Henkus, 2009*) An SR of 6 moderate quality studies comparing arthroscopic acromioplasty with bursectomy alone similarly concluded that both had equal outcomes. (*Donigan, 2011*) Another RCT also concluded that arthroscopic acromioplasty provided no clinically important effects at 24-months over a structured and supervised exercise program regarding subjective outcome or cost-effectiveness, suggesting that surgery be offered only very judiciously. (*Ketola, 2009*) Even between 2004 until 2009 American Board of Orthopedic Surgery examinees already demonstrated a decreasing frequency of isolated arthroscopic SAD or in association with rotator cuff repair. (*Mauro, 2012*)

Recent research: An RCT further showed that full-thickness rotator cuff repair outcomes were the same at 2 years with or without acromioplasty, with SAD failing to improve outcomes. (*Abrams, 2014*) An SR of 15 low-to-moderate quality trials demonstrated that SAD, either open or arthroscopic is no more effective than exercises for rotator cuff tendinopathy. (*Toliopoulos, 2014*) An SR/meta-analysis (MA) of 33 RCTs reported that arthroscopic combined acromioplasty/bursectomy is better than open techniques for SIS, although exercise alone has similar long-term outcomes to surgery. Multiple modality treatment including home exercise is better than single-intervention therapies. Injection combined with exercise improves outcomes, while injection alone worsens them. (*Dong, 2015*) An MA of 4 RCTs and 347 SIS patients reported no significant differences in changes of pain intensity between surgically and conservatively treated subjects. (*Saltychev, 2015*) A prospective cohort of 75 arthroscopic SAD patients resistant to 6 months of conservative treatment had some pain relief, but over 50% failed to achieve normal shoulder function or active range-of-motion at 2-years. (*Konradsen, 2015*) A large case-series of 95 SAD (without cuff repair) procedures followed for *20 years* had an overall failure rate of 21%, with 15% undergoing revision surgery. Failures increased to 29% with presence of full-thickness cuff tears, and 35% with calcific tendonitis. (*Jaeger, 2016*)

A prospective multi-center placebo-controlled RCT of 90 SAD, 94 arthroscopy (bursectomy), and 90 NO treatment groups with “subacromial pain” (at least 3 months, no rotator cuff tear) demonstrated marginally better outcomes for surgery at 6 months, although there was no additional benefit for acromioplasty. The

value of acromioplasty is seriously questioned, with any surgical benefits possibly due to placebo effect or addition of post-operative therapy. (*Beard, 2017*) 12-year follow-up of a previous RCT of 140 rotator cuff tendinopathy patients randomized to SAD plus supervised exercise vs. supervised exercise alone, with 64% original patients returning questionnaires, found no significant difference in long-term outcomes between groups. (*Ketola, 2017*) An SR/MA of 200 RCTs emphasizes the benefit of physical (manual) therapy combined with home exercise for shoulder impingement. Specific exercises are superior to generic exercises, and NSAIDs, corticosteroid injections, and taping have shown some effectiveness, although evidence quality is generally low. (*Steuri, 2017*)

Worker's Compensation: A retrospective multi-center cohort study of 108 isolated SAD procedures reported a failure rate of 29%, with major risk factors being worker's compensation status and distal clavicle "co-planing", while minor factors included calcific tendinopathy and deep partial-thickness cuff tears. Utmost caution was advised regarding SAD for injured workers. (*Bouchard, 2014*) An SR specifically focused on workers with rotator cuff tendinopathy concluded that low-to-moderate evidence supported the effectiveness of therapeutic (clinical setting) exercise resulting in better function and return-to-work, as well as similar outcomes for workers when comparing surgery with exercise treatment alone. Moderate evidence showed exercise to be better than placebo or no treatment. (*Desmeules, 2016*)

On the date of this medical contested case hearing, the ODG provides the following with regard to shoulder surgery for rotator cuff repair:

***ODG Indications for Surgery*™ -- Rotator cuff repair:**

Criteria for rotator cuff repair with diagnosis of *moderate to large 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:** Weakness with abduction/external rotation testing. May also have mild atrophy of shoulder musculature. Should have full passive range of motion. PLUS
3. **Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views AND MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff *without significant fatty infiltration* (atrophy).

Criteria for rotator cuff repair AND/OR anterior acromioplasty with diagnosis of *small full-thickness or partial-thickness* rotator cuff tear OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is generally adequate if treatment has been continuous, six months if treatment has been intermittent. Exercise must be directed toward gaining full ROM, with both stretching and strengthening to balance muscles. Earlier surgical intervention may be required with failure to progress with therapy, high pain levels, and/or mechanical catching. 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 have mild atrophy of shoulder musculature, AND Tenderness over rotator cuff, greater tuberosity, or anterior acromial area. AND Positive impingement signs 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 views AND MRI, ultrasound, or arthrogram shows positive evidence of at least partial deficit in rotator cuff without significant fatty infiltration (atrophy).

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

Risk versus benefit:

Repair of rotator cuff tears can improve pain and function for carefully selected patients, although conservative treatment has reported outcomes often equivalent to surgical management, but without surgical risks. Results following physical therapy, debridement/acromioplasty, and rotator cuff repair for symptomatic *non-traumatic* rotator cuff tears were similar at mid-term follow-up. One-third of rotator cuff repairs ultimately fail, 3 out of 4 within three months of surgery. The re-tear rate has been somewhat predictable based on tear size, between 10% for ≤2 cm2 up to almost 60% for >8 cm2. Surgical outcomes are much better in younger patients who are less likely to have degenerative changes. Outpatient rotator cuff repair is well-accepted and relatively cost effective. Workers' compensation status and/or diabetes predict generally worse outcomes following repair. Revision repairs are inferior to primary, having doubled failure rates at 2 years. Post-operative infection following cuff repair has been <1% overall, but higher for open approaches and male sex. Open repairs also have more than double the incidence of early complications (infection, readmission, or return to surgery) compared to arthroscopic procedures. Problematic postoperative stiffness

occurs in 5-10% of arthroscopic repairs. Fatty infiltration on pre-operative MRI portends poor surgical outcomes. *For specific research and discussion see below*.

Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly when acute for younger working individuals. However, rotator cuff tears are frequently only partial-thickness or smaller full-thickness tears. These present primarily as subacromial impingement, and surgery is reserved for cases failing conservative therapy for at least three months. 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 early degeneration to full avulsions. "Full-thickness tear", also called complete tear, has been defined as a split of the soft tissue into two pieces, basically creating a hole in a portion or the entire tendon. "Partial-thickness tear" represents damage to the soft tissue without completely severing it. (*AAOS, 2011*) Partial-thickness tears are commonly described either on MRI or during arthroscopy based on a percentage of the "thickness" or depth of the tendon involved, with higher numbers representing worse tearing. Partial-thickness tearing can occur on either the articular side (undersurface) or subacromial side (outer or superior surface). As a continuum of the impingement process, eventually a hole (small full-thickness tear) can develop, most commonly at the anterior insertion of the supraspinatus. Studies of normal subjects document the universal presence of degenerative tearing including full avulsions without symptoms. Conservative treatment can have results similar to surgical treatment but without surgical risks. Studies of conservative treatment for full-thickness tears have demonstrated 82-86% success for patients presenting within three months of injury. Surgical outcomes are much better in younger patients with rotator cuff tears, than in older patients who often have degenerative changes. Surgical consultation is indicated for patients who have: Activity limitations for more than three months, plus a surgical lesion; Failure of exercise programs to increase range of motion and strength of the shoulder musculature; Clear clinical and imaging evidence of a surgically repairable lesion; Red flag conditions (e.g., acute full-thickness cuff tear in a young working individual, glenohumeral joint dislocation, etc.). Proven traumatic tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, most of these tears are 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*) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopedic surgeons regarding indications for 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 after 6 to 12 weeks of conservative treatment. (*Burbank2, 2008*) Patients with workers' compensation claims have worse outcomes following rotator cuff repair. (*Henn, 2008*) An incidence of problematic postoperative stiffness occurs in about 5% of arthroscopic repairs, being higher with calcific tendinitis, age under 50, and worker's compensation status. (*Huberty, 2009*)

Evidence regarding various operative and nonoperative treatments for rotator cuff tears has been limited and inconclusive, according to an AHRQ comparative effectiveness review. While data is sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were relatively rare. A majority of patients completes a course of physical therapy before considering surgery, but there is very little good quality research to guide the type or timing of nonoperative treatment, or who might best benefit from various modalities. Most studies found no difference in health-related quality of life, function, pain, range of motion, and strength with one therapy approach versus another (e.g., with or without aquatics, individualized vs at home, videotape vs therapist-based, etc.). Four of the 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 noted little difference in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with or without acromioplasty, and single-row vs double-row fixation. 11 trials showed moderate evidence for no differences in function or pain. In 72 studies assessing prognostic factors, older age, increasing tear size, and worse preoperative symptoms were consistently associated with recurrent tears; whereas gender, workers' compensation status, and duration of symptoms was not generally predictive of poorer outcomes. Adding continuous passive motion to postoperative physical therapy does not appear to be helpful; (*Seida, 2010*) A prospective cohort study concluded that PT is effective for most patients with *atraumatic* full-thickness rotator cuff tears and shoulder pain, without a need for surgery. By six weeks fewer than 10% of patients had elected surgery; and at 2 years only 2% of those remaining had subsequently opted for surgery. (*Kuhn, 2011*) One-third of rotator cuff repairs re-tear, with 74% of the failures occurring within three months of surgery. Healed tendons at six months are predictive of good outcomes at seven years. (*Kluger, 2011*) Not surprisingly, larger tears are more difficult to successfully repair. The re-tear rate based on rotator cuff tear size is: 10% for ≤2 cm2; 16% for 2–4 cm2; 31% for 4–6 cm2; 50% for 6–8 cm2; & 57% for >8 cm2 (*Murrell, 2012*) There is insufficient evidence to suggest comparative efficacy for operative vs nonoperative treatment

of rotator cuff tears in in patients aged older than 60 years. (*Downie, 2012*) An RCT demonstrated that full-thickness rotator cuff repair outcomes were the same, with or without acromioplasty. Acromioplasty is often added at the time of arthroscopic cuff repair, but it does not necessarily improve outcomes at 2-years. (*Abrams, 2014*) Non-contrast MRI is sufficient for rotator cuff tear diagnosis. (*Spencer, 2013*) (*Farshad-Amacker, 2013*) (*Arnold, 2012*) (*Major, 2011*)

Recent research: Conservative treatment is a good option for the initial treatment of isolated, symptomatic, *non-traumatic,* supraspinatus tears in older patients as demonstrated by an RCT comparing the effectiveness of physical therapy, simple acromioplasty, or cuff repair; there was no significant difference in clinical outcomes among differing interventions at 2-years. (*Kukkonen, 2015*) There is little evidence that the outcomes of rotator cuff repair are improving, according to a systematic review (SR) of 108 articles, including 8011 shoulders, where the mean re-tear rate was 27% at 2-years, being associated with *fatty infiltration* on MRI, larger tear size, advanced age, and double-row repairs. Patient reported outcomes were generally improved regardless of whether the repair ultimately restored tendon integrity. (*McElvany, 2015*) Another SR noted mixed results, some studies showing improved function and strength with intact repairs, but others reporting that tendon re-tear does not lead to inferior clinical outcomes. (*Galanopoulos, 2017*) A retrospective multi-center cohort of 288 isolated supraspinatus repairs followed for 10-years indicated that complications occurred in 10% (mostly stiffness), and that pre-operative *fatty infiltration* and post-operative cuff re-tear resulted in significantly worse long-term outcomes. (*Collin, 2017*) Another retrospective cohort of 442 rotator cuff repairs followed for 3-years reported that 19% failed to heal, but of those only 45% showed subsequent increase in tear size. Healed tendons had better function than non-healed, and non-progressive re-tears (MRI at 6-months) showed better function and strength than progressive ones. (*Jeon, 2017*) A prospective study of 55 patients having rotator cuff surgery noted similar functional outcomes between surgically observed findings of tendinosis/partial-thickness tears and full-thickness tears. (*Hsu, 2017*) Post-operative infection rates for 1,824 rotator cuff repairs (open, mini-open, and arthroscopic) was 0.77% overall, but significantly lower for both arthroscopic approach and female sex. (*Vopat, 2016*) A population analysis involving 175,000 patients with 1/3 being diabetic, noted both cuff repair incidence and surgical hazard ratios to be 33% higher among diabetes, showing this disease to be an independent negative risk factor. (*Huang, 2016*) Significantly lower early complications (infection, readmission, or return to surgery) were reported among veterans undergoing arthroscopic (0.9%) vs. open repairs (2.1%). (*Owens, 2015*)

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*) Although revision rotator cuff repair had similar short-term outcomes with primary surgery, by 2 years symptomatic re-tearing was twice as likely. (*Shamsudin, 2015*)

Irreparable rotator cuff tear surgery: 151 debridement/smoothing procedures for irreparable cuff tears with retained active elevation followed for 7-years showed clinically significant improvement in 70% of patients. (*Hsu, 2017*)

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet his burden of overcoming the IRO decision in regard to a right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair, by a preponderance of the evidence-based medicine. However, based on the testimony of Dr. S and the IRO decision itself, the claimant sustained his burden of proof to show that a right shoulder arthroscopy with subacromial decompression only is reasonable and necessary medical treatment for the compensable injury of (Date of Injury). The IRO decision in this case is based on the ODG, and the evidence revealed that the claimant failed to meet all of the necessary criteria for right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair prescribed in the ODG. However, the claimant did meet all of the necessary criteria for the right shoulder arthroscopy with subacromial decompression only. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO in regard to a right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair and, consequently, the claimant is not entitled to that procedure. However, the preponderance of the evidence-based medicine does support the claimant's entitlement to a right shoulder arthroscopy with subacromial decompression only.

The Administrative Law Judge 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 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 of a right shoulder strain.

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

E. The IRO determined that the claimant is not entitled to right shoulder arthroscopy with subacromial decompression or a right shoulder arthroscopy with subacromial decompression, and distal clavicle excision debridement of the rotator cuff or rotator cuff repair.

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 Administrative Law Judge's Exhibit Number 2.

3. Right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair is not health care reasonably required for the compensable injury of (Date of Injury).

4. Right shoulder arthroscopy with subacromial decompression only 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 not contrary to the decision of the IRO that right shoulder arthroscopy with subacromial decompression, and distal clavicle excision debridement of the rotator cuff or rotator cuff repair is not health care reasonably required for the compensable injury of (Date of Injury).

4. The preponderance of the evidence is contrary to the decision of the IRO that right shoulder arthroscopy with subacromial decompression only is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

The claimant is not entitled to a right shoulder arthroscopy with subacromial decompression and distal clavicle excision debridement of the rotator cuff or rotator cuff repair for the compensable injury on (Date of Injury).

The claimant is entitled to right shoulder arthroscopy with subacromial decompression only for the compensable injury on (Date of Injury).

ORDER

The carrier is not liable for a right shoulder arthroscopy with subacromial decompression, and distal clavicle excision debridement of the rotator cuff or rotator cuff repair. The carrier is liable for a right shoulder arthroscopy with subacromial decompression only. 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 **TEXAS MUTUAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is:

RICHARD J. GERGASKO, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TX 78723

Signed this 13th day of February, 2018.

William M. Routon II
Administrative Law Judge