MEDICAL CONTESTED CASE HEARING NO. 18007

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 preponderance of the evidence is not contrary to the decision of the IRO that Claimant is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on March 7, 2018, 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 a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

EVIDENCE PRESENTED

The following witnesses testified:

> For Petitioner/Claimant: Claimant.
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> For Respondent/Carrier: BS, M.D.

The following exhibits were admitted into evidence:

> Administrative Law Judge's Exhibits: ALJ-1 and ALJ-2.
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> Petitioner/Claimant's Exhibits: C-1 through C-7.
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> Respondent/Carrier's Exhibits CR-A through CR-H.

DISCUSSION

It is undisputed that Petitioner/Claimant (Claimant) sustained a compensable injury on (Date of Injury). The evidence showed that Claimant injured his right lower extremity when he jumped from a 4-foot height and landed on his right heel. Claimant testified that he has not been able to return to work due to the pain and limitations stemming from his injury. Claimant's current treating podiatrist, DB, D.P.M., recommended Claimant undergo a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury). Dr. B's pre-authorization request for the medical treatment was sent to a Utilization Review Agent (URA) doctor, GG, M.D., who denied the request because the recommended treatment was not medically necessary. A second request was submitted for reconsideration, and another URA doctor, SG, D.P.M., found the recommended procedures were not medically necessary. Claimant appealed the denials through an Independent Review Organization (IRO), and the IRO doctor upheld the previous denials.

Claimant requested the medical contested case hearing because he contended the preponderance of the evidence is contrary to the decision of the IRO that he is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury). Respondent/Carrier (Carrier) argued the decision of the IRO should be upheld.

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."

The ODG provides the following guidelines concerning the peroneus longus tenolysis and screw removal:

Peroneal tendinitis/tendon rupture (treatment)

> Recommend conservative treatment for tendinitis, and surgery as an option for a ruptured tendon.
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> Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. Peroneal tendonitis is an irritation to the tendons that run past the back outside part of the ankle, and it is a common cause of lateral ankle pain. Commonly it is an overuse condition that responds to conservative treatment, but if it is left untreated it can progress to a complete tendon rupture. Predisposing factors for peroneal tendonitis and rupture include varus alignment of the hindfoot and peroneal subluxation and dislocation. Participation in certain sports, including downhill skiing, skating, ballet, running and soccer creates higher risk for peroneal tendon tears. If caught early, peroneal tendonitis or instability may be treated conservatively with NSAIDs, immobilization and avoidance of exacerbating activities. Once secondary changes in the tendon occur, however, surgical treatment often becomes necessary. Surgery is indicated in the acute phase for peroneus brevis tendon rupture, acute dislocation, anomalous peroneal brevis muscle hypertrophy, and in peroneus longus tears that are associated with diminished function. (*Cerrato, 2009*).

Hardware implant removal (fracture fixation)

> Not recommended for routine removal of hardware implanted for fracture fixation, except with exposed or prominent pins, broken hardware, or persistent pain after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection.

> Removal of hardware is appropriate for some situations where fractures may not be involved. Pins stabilizing a joint following ligament or tendon repair must eventually be removed so that the joint can resume function (e.g. a pin across the DIP joint of a finger to stabilize an extensor tendon repair, or temporary wrist stabilization following scapholunate or other ligament reconstruction).
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> Although hardware removal is commonly performed, it should not be considered a routine procedure. The decision to remove hardware has significant economic implications, including the costs of the procedure as well as lost work time during recovery. Implant removal can be challenging and result in complications like neurovascular injury, re-fracture, or deformity recurrence. Current literature does not support routine removal of implants to protect against allergy, carcinogenesis, or metal detection. (*Busam, 2006*). Despite advances in metallurgy, fatigue failure of hardware is common when fractures fail to heal. Revision procedures can be difficult, usually requiring removal of intact or broken hardware. (*Hak, 2008*). Following fracture healing, improvements in pain relief and function can be expected after removal of hardware in those patients who still have persistent pain in the region of implanted hardware, after ruling out other causes of pain such as infection and nonunion. (*Minkowitz, 2007*).
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> Routine removal of orthopedic fixation devices after fracture healing remains an issue of debate, but implant removal in symptomatic patients is rated to be moderately effective. Most surgeons have abandoned historically routine implant removal, and do not believe there are clinically significant adverse effects of retained metal implants. Given the frequency of the procedure in orthopedic departments worldwide, there is a need for a large randomized trial to determine true efficacy and effectiveness of implant removal with regard to patient-centered outcomes. (*Hanson, 2008*).

The ODG does not address the right lateral heel exostectomy, sural nerve decompression, and ankle arthrotomy with synovectomy. According to ODG Appendix D, in cases where the medical treatment is not covered in the ODG, the physician determining medical necessity of the medical care at issue should consider (1) extenuating circumstances of the case that would warrant additional treatment including the rationale for procedures not addressed in ODG; (2) patient co-morbidities; (3) objective signs of functional improvement for treatment conducted thus far for the injured worker; (4) measurable goals and progress points expected from additional treatment; and (5) any additional evidence provided by the health care provider to support the medical necessity of the medical care at issue.

According to the IRO doctor, the CT scan showed the subtalar joint was only partially fused, and Claimant would need a complete or nearly complete fusion to relieve his pain. The doctor specified that the procedures recommended by Dr. B would not address the objective issues. The

doctor indicated that the tenolysis of the peroneal tendon alone would not provide adequate treatment for the problem, and the significant objective evidence did not support a large lateral exostosis was causing further problems. The doctor specified that there were issues revolving around the superficial branch of the peroneal nerve entering the peroneus longus muscle more proximally, but the medical evidence did not document this issue was addressed. He opined, that in all medical likelihood, the majority of Claimant's dysfunction and pain is coming from an incompletely fused subtalar joint, and the proposed procedures do not address that issue. After his review of the medical documentation, the IRO doctor determined the recommended treatment including right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy were not procedures that are appropriate or medically necessary for the injury.

Carrier offered testimony from BS, M.D., who reviewed the medical records and agreed with the IRO doctor's opinion.

Since Claimant was challenging the IRO, he had the burden to prove the evidence-based medical evidence is contrary to the IRO decision through the opinion of a qualified expert that is supported by evidence-based medical evidence. In support of his position, Claimant relied on the totality of the medical evidence presented and Dr. B's answers to questions sent by his ombudsman. Dr. B indicated that he requested several procedures to avoid multiple surgeries, and Claimant had failed conservative treatment. He also stated that Claimant's heel injury caused a lateral exostosis and post-traumatic degenerative joint disease that were directly related to the injury. However, he did not provide an analysis based on evidence-based medical evidence persuasively explaining why the preponderance of the evidence-based medical evidence was contrary to the IRO decision. Although Claimant's testimony regarding his pain and limitations was credible, he did not meet his burden.

Consequently, the preponderance of the evidence was not contrary to the IRO decision, and Claimant is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury).

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 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 with Texas Mutual Insurance Company, Carrier.

D. On (Date of Injury), Claimant sustained a compensable injury.

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 Administrative Law Judge's Exhibit Number 2.

3. The IRO determined Claimant is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy.

4. A right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy 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 Claimant is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy for the compensable injury of (Date of Injury).

DECISION

The preponderance of the evidence is not contrary to the decision of the IRO that Claimant is not entitled to a right lateral heel exostectomy, peroneus longus tenolysis, sural nerve decompression, screw removal, and ankle arthrotomy with synovectomy 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 of the Act.

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
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 15th day of March, 2018.

Kara Squier
Hearing Officer