MEDICAL CONTESTED CASE HEARING NO. 18016

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. For the reasons discussed herein, the Administrative Law Judge determines that Claimant is not entitled to right shoulder revision reverse total surgery arthroplasty for the compensable injury of (Date of Injury).

ISSUES

A contested case hearing was held on May 7, 2018 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to right shoulder revision reverse total surgery arthroplasty for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by BC, ombudsman. Respondent/Carrier appeared and was represented by CM, attorney. GW was present on behalf of the Employer.

EVIDENCE PRESENTED

The following witnesses testified:

> For Claimant: Claimant.
>
> For Carrier: None.

The following exhibits were admitted into evidence:

> Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.
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> Claimant's Exhibits C-1 through C-6.
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> Carrier's Exhibits CR-A through CR-D.

BACKGROUND INFORMATION

Claimant contested the determination of the IRO doctor who determined that he is not entitled to right shoulder revision reverse total surgery arthroplasty for the compensable injury of (Date of Injury). He relied on his medical records and primarily on the opinion of Dr. JR, treating

physician. Carrier argued that Claimant offered insufficient evidence-based medicine to overcome the IRO decision, which is based on the Official Disability Guidelines (ODG).

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 addresses the shoulder arthroplasty as follows:

> Recommended after 6 months of conservative treatment for selected patients. Recommend total shoulder arthroplasty over hemiarthroplasty. While less common than knee or hip arthroplasty, shoulder replacement is a safe and effective procedure for patients with osteoarthritis or rheumatoid arthritis. (*van de Sande, 2006*)

See also *Reverse shoulder arthroplasty; Arthroscopic debridement* (for shoulder arthritis); and *Surgery for AC joint* (arthritis, separation). For average hospital LOS if criteria are met, see *Hospital length of stay* (LOS).

ODG Indications for Surgery™ -- Shoulder Arthroplasty:

A. Glenohumeral joint osteoarthritis, post-traumatic arthritis, or rheumatoid arthritis with all of the following:
    1. Severe pain (preventing a good night's sleep) or functional disability that interferes with activities of daily living or work; &
    2. Positive radiographic findings (e.g., shoulder joint degeneration, severe joint space stenosis); &
    3. Conservative therapies (including NSAIDs, intra-articular steroid injections, and physical therapy) have been tried for at least 6 months and failed; &
    4. Body Mass Index less than 40, with documented significant weight loss effort for BMI>35; &
    5. If rheumatoid arthritis only, tried and failed anti-cytokine agents or disease modifying anti-rheumatic drugs;

B. Treatment of proximal humeral fracture nonunion, malunion, or avascular necrosis

C. Not recommended if irreparable rotator cuff tear, in young individuals, or in individuals with active local or systemic infection.

Risk versus benefit: Since hemiarthroplasty has almost double the revision rate of total shoulder arthroplasty, as well as poorer functional and pain outcomes, it is less favored despite having a slightly smaller complication rate. The 12% incidence of surgical complications with TSA is less than that of other large joint arthroplasties and hospital length of stay is shorter. Surgical site infection has been remarkably low, less than 0.1%. (*Smucny, 2015*) Bleeding complications resulting in transfusion occurs in 4% of TSA patients, with major morbidity of 2%. (*Anthony, 2015*) Early revision has been associated with age less than 65, smoking and obesity. Dislocation and component loosening were the most common reasons for early revision. (*Werner, 2015*) High rates of satisfactory or excellent outcomes have been reported with TSA performed for osteoarthritis or rheumatoid arthritis, although return to work and outcomes are worse for WC patients.

Caution is advised in worker's compensation patients since outcomes tend to be worse in these patients. (*Chen, 2007*) In a review of 994 shoulder arthroplasties compared with 15,414 hip arthroplasties and 34,471 knee arthroplasties performed for osteoarthritis, patients who had shoulder arthroplasties had, on

average, a lower complication rate, a shorter length of stay, and fewer total charges. (*Farmer, 2007*) The most common indication for total shoulder arthroplasty is osteoarthritis, but for hemiarthroplasty it is acute fracture. There was a high rate of satisfactory or excellent results after total shoulder arthroplasty for osteoarthritis, but hemiarthroplasty offered less satisfactory results, most likely related to the use of this procedure for trauma. (*Adams, 2007*) At a minimum of two years of follow-up, total shoulder arthroplasty provided better functional outcome than hemiarthroplasty for patients with osteoarthritis of the shoulder. (*Bryant, 2005*) According to a recent study, total shoulder arthroplasty (TSA) allows many patients to participate in sports without significant restriction of their level of activity. They found that, of the patients who took part in sports before having shoulder disease, 89 percent were still able to participate after a mean follow-up of 2.8 years. In addition, of patients that had given up sports before TSA, 65% resumed activities after joint replacement. No patient had to stop participating in sports because of the TSA. Strength and range of motion, as well as the physical component summary of the SF-36, were significantly better in the sports group after TSA than in the non-sports group. (*Schumann, 2010*)

Total shoulder arthroplasty (TSA) and hemiarthroplasty (HA) are treatment choices for end-stage shoulder osteoarthritis. The decision of whether to use TSA or HA is controversial. The available evidence suggests that TSA is more effective than HA for patients with shoulder arthritis. Compared with HA, TSA presents with a higher UCLA shoulder scale and a higher ASES. There was no significant difference between TSA and HA for revision, WOOS, and incidence of instability. HA had a lower operation time. (*Duan, 2013*) Total shoulder arthroplasty leads to significant improvements in scores for function and pain. Shoulder-specific measures of function consistently showed the greatest degree of improvement, with large effect sizes. Total shoulder arthroplasty also leads to significant improvements in overall physical wellbeing, with a moderate-to-large effect size. (*Carter, 2012*) Total shoulder arthroplasty (TSA) was associated with better shoulder function, with no other demonstrable clinical benefits compared to hemiarthroplasty. There were no controlled trials of surgery versus placebo or nonsurgical interventions. Significantly worse scores on the American Shoulder and Elbow Surgeons scale and a non-significant trend toward higher revision rate were noted in hemiarthroplasty compared to TSA. (*Singh, 2011*) This systematic review concluded that TSA results in less need for revision surgery, but has a trend to result in more complications. The revision rate for HA (13%) was higher than TSA (7%), and the complication rate for TSA (12%) was higher than HA (8%). The weighted mean improvement in anteflexion, exorotation and abduction were respectively 33°, 15° and 31° in the HA group and were respectively 56°, 21° and 48° in the TSA group. Mean decrease in pain scores was 4.2 in the HA

> and 5.5 in the TSA group. (*van den Bekerom, 2013*) A study of postoperative outcomes of total shoulder arthroplasty (TSA) between patients receiving workers' comp (WC) benefits and a control group that did not, concluded that the outcomes are relatively worse in the WC patients. A significant number of WC patients are unable to return to work after TSA. (*Jawa, 2015*) An institutional joint registry analysis of 4,567 consecutive shoulder arthroplasties included 1,622 patients with BMI 30-40 kg/m, and 297 with BMI over 40. For patients with BMI over 30, each additional one-unit increase was associated with a 5% increase in risk of revision for mechanical failure, and 9% for superficial wound infection. [BMI 35 = 25%/45%, BMI 40 = 50%/90% increased risk] The authors concluded that increasing BMI is strongly associated with increased revision rates and postoperative complications. (*Wagner, 2017*)

The IRO reviewer agreed with two utilization review doctors and opined that the requested treatment did not meet ODG criteria. Specifically, the IRO reviewer noted that "[t]he arthroscopic finding would support that the rotator cuff is irreparable." IRO reviewer further noted that "the records still do not document failure of at least 6 months of reasonable non-operative measures to include injections, formal physical therapy, or medications." Both utilization review doctors had made recommendations that were consistent with the IRO reviewer's opinion regarding the requested surgery.

Claimant provided an opinion from Dr. R who opined that Claimant required the requested treatment. Dr. R noted that, "[Claimant] is struggling with pain, discomfort, and significant loss of function of this arm. Dr. R further opined that "[Claimant] would benefit from a reverse total shoulder arthroplasty."

Dr. R's opinion did not establish that the preponderance of the evidence is contrary to the IRO decision. Dr. R does not cite evidence-based medical studies to rebut the ODG, nor does he explain why the ODG does not apply in this situation. Dr. R's opinion is insufficient to overcome the IRO decision nor do the medical records in evidence rebut the explanation of the IRO reviewer.

Claimant has the burden of proof on this case to show by the preponderance of evidence-based medical evidence that the disputed procedure is health care that is clinically appropriate and considered effective for his injury. Evidence-based medical evidence entails the opinion of a qualified expert that is supported by evidence-based medicine. The evidence presented at the hearing is found to be insufficient to constitute evidence-based medical evidence to overcome the decision of the IRO reviewer. As Claimant did not overcome the IRO decision by a preponderance of the evidence-based medical evidence, he has accordingly failed to meet his burden of proof.

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 through (Carrier), Carrier

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

   E. The Independent Review Organization determined Claimant should not have right shoulder revision reverse total surgery arthroplasty for the compensable injury of (Date of 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. Right shoulder revision reverse total surgery arthroplasty 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 right shoulder revision reverse total surgery arthroplasty for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to right shoulder revision reverse total surgery arthroplasty 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 **(CARRIER)**, and the name and address of its registered agent for service of process is

(NAME)
(ADDRESS)
(CITY)(STATE)(ZIPCODE)

Signed this 8th day of May, 2018.

Travis Dupree
Administrative Law Judge