

MEDICAL CONTESTED CASE HEARING NO. 18023

**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 (ALJ) determines that:

Claimant is not entitled to the requested right hip arthroscopy, labral repair vs. debridement.

**ISSUES**

A contested case hearing (CCH) was held on September 5, 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 hip arthroscopy, labral repair vs. debridement?

**PARTIES PRESENT**

Petitioner/Claimant (Claimant) was present, and represented by SL, attorney. Respondent/Carrier (Carrier) appeared and was represented by BJ, attorney.

**EVIDENCE PRESENTED**

The following witnesses testified:

For Claimant: Claimant.

For Carrier: BS, M.D.

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 through ALJ-3.

Claimant's Exhibits C-1 through C-15.

Carrier's Exhibits CR-A through CR-I.

Claimant's Exhibits C-9 and C-10 were not admitted at the onset as they were not timely exchanged, and contained articles that could have been obtained and exchanged prior to the exchange deadline. During the development of the evidence, on the ALJ's own motion, and a

finding of good cause, these Exhibits were admitted to provide illustration for one of Claimant's admitted exhibits, an affidavit from Dr. BS.

## **DISCUSSION**

Claimant sustained a compensable injury on (Date of Injury). The parties stipulated that the compensable injury extends to and includes a low back strain and right (hip) acetabular labrum tear. Claimant credibly testified regarding how he was injured, his medical treatment to date, and his physical limitations resulting from the compensable injury. A prior CCH was held on January 25, 2018, to determine whether the compensable injury extended to and included a tear of the right (hip) acetabular labrum. Following the issuance of the Decision and Order finding that the compensable injury did extend to and include the aforementioned right acetabular tear, Claimant's orthopedic surgeon, BS, M.D., recommended a right hip arthroscopy, labral repair vs. debridement. Dr. S submitted a preauthorization request for the proposed procedure on March 29, 2018. Included with the one page preauthorization request were two office visit reports of two office visit with Dr. S, dated July 25, 2017, and March 23, 2018.

A utilization review was completed on April 4, 2018, and the requested preauthorization was not certified. GG, M.D., an orthopedic surgeon, performed the review and determined that Claimant did not meet the Official Disability Guidelines (ODG) criteria for the proposed procedure. Specifically, Claimant was over the age of 50, his Body Mass Index (BMI) was more than 30, and there was no evidence of pain relief demonstrated with a diagnostic intra-articular anesthetic injection. Finally, the requesting physician failed to provide a copy of the MRI report in his request. Dr. G's adverse determination was appealed on April 13, 2018, and reviewed on appeal by JR, M.D., an orthopedic surgeon. On April 20, 2018, Dr. R agreed with Dr. G's determination that the request for surgery was not supported by the evidence presented, which included the records of two office visits with Dr. S.

Dr. S did not agree with the non-certification, and requested a review by an Independent Review Organization (IRO) on May 21, 2018. On June 11, 2018, and amended on June 20, 2018, the Medical Doctor licensed by the Texas State Board of Medical Examiners, who specializes in Orthopedic Surgery, and is engaged in the full time practice of medicine performed the review. The IRO determined that the Claimant is not entitled to right hip arthroscopy, labral repair vs. debridement. There were numerous reasons provided for the non-authorization. In particular, Claimant did not exhaust lower levels of care, the ODG would not support surgery for labral abnormalities on an individual with BMI over 30, or for those over the age of 50. Again, the MRI was not submitted (films or report).

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 for the requested procedure indicates the following:

*ODG INDICATIONS FOR SURGERY™ -- HIP AND PELVIS (ACUTE AND CHRONIC):*

*Indications for arthroscopy:*

For more specific indications, see *Surgery for femoroacetabular impingement (FAI); Repair of labral tears.*

For all other diagnoses except emergency conditions such as intra-articular fracture or infection:

\* Symptomatic hip pain and dysfunction refractory to at least 6 weeks of conservative treatment, including rest, anti-inflammatory medications, and physical therapy

\* MRI and/or X-rays demonstrate clear pathology consistent with an arthroscopically treatable diagnosis ("diagnostic" arthroscopy is inappropriate for the hip)

- \* Absent or minimal arthritic changes (Tonnis 0 or 1) AND hip joint space >2 mm AND no chondral defects or subchondral cysts
- \* Under age 50
- \* Body mass index (BMI) <30
- \* No prior ipsilateral surgery for FAI, labral tears, chondral lesions, arthritis, infection, or hip dysplasia

**Risk versus benefit:**

An SR of 81 primary hip arthroscopy studies involving 9,317 patients noted that over 90% met “minimal clinically important difference” (MCID) standards and that 5.8% went on to revision arthroscopy with another 5.5% to total hip arthroplasty at just under 3 years. (*Levy, 2016*) A cohort of 931 primary hip arthroscopies showed 77% patient satisfaction, 4.3% overall complications, and 5.6% conversion to arthroplasty at 2 years. (*Domb, 2016*) An SR of 53 studies/8189 hips reported a 7.9% major and 0.5% minor complication rate following hip arthroscopic procedures at 2 years. The most common major complications were the result of excessive soft tissue fluid extravasation. (*Weber, 2015*) Another series of 595 hip arthroscopies reported 7.7% requiring revision arthroscopy and 9.1% going on to arthroplasty at 2 years, with increasing age being the most significant risk factor. (*Gupta, 2016a*) The risks of almost 8% major complications combined with up to 17% short-term failure requiring re-operation demonstrates that risk may exceed benefit for many hip arthroscopy candidates. Since these reported outcomes are significantly worse than for knee or shoulder arthroscopy, patient selection should be very judicious, and shared decision-making is critical.

The two most common applications of hip arthroscopy include acute labral tears and post-traumatic femoroacetabular impingement (FAI). For specific indications regarding these conditions, see *Surgery for femoroacetabular impingement (FAI); Repair of labral tears*. Other less common applications include osteochondral fractures, loose bodies, capsular laxity/instability, isolated chondral lesions/osteochondritis dissecans, gout/pseudogout, and pigmented villonodular synovitis (PVNS).

Evidence-based literature is sparse regarding these and other rare hip conditions, limited primarily to small case series. Therefore, surgical planning and rationale must be well documented with specifically defined goals on a case-by-case basis. The presence of advancing arthritic changes or significant dysplasia is a contraindication to hip arthroscopy. Also, repeat (revision) arthroscopic surgery has relatively poor supportive evidence and cannot generally be recommended. There continues to be a paucity of mid- to long-term outcome studies following hip arthroscopic procedures, which raises serious questions regarding true efficacy for the prevention or delay of progressive hip arthropathy.

**Diagnostic intra-articular injection:**

The response to 93 pre-operative anesthetic hip injections in patients having subsequent hip arthroscopy failed to correlate or predict surgical results at one year. However, in the same cohort, BMI <25 was associated with much better outcomes. (*Ladd, 2016*) The poor predictive value of pre-operative intra-articular diagnostic injections was confirmed in another 96 hips with labral tears (adjusted for chondral pathology), suggesting a limited role for such injections. (*Krych, 2016*) Even so, a systematic review (SR) including 7 studies/337 patients concluded that non-response (no significant pain relief) to injection was a strong negative predictor of surgical outcome. The greatest response to injection was seen with acetabular chondral injury, and the least with cam impingement. (*Lynch, 2016*) Another SR with 8 studies/281 FAI hips also reported that a negative response to pre-operative injection is predictive of a poor surgical outcome. Only a 15% positive response to corticosteroid injections was seen in this group at 6 weeks. (*Khan, 2015*) Diagnostic injection appears to be predictive when little if any pain relief results, portending a poor outcome with arthroscopic treatment. Therefore, a positive response supports arthroscopic intervention and should be strongly considered for questionable interventions.

**Age and Weight:**

An analysis of 1577 patients reported a 5.3 % incidence of post hip arthroscopy conversion to total hip arthroplasty within 4 years. Age over 50 and the inclusion of chondroplasty or presence of osteoarthritis were predictive of significantly higher conversion rates. (*Bedard, 2016*) Aging was noted to be the most significant risk factor for re-operation within 2 years. (*Gupta, 2016a*) Increasing BMI was associated with significantly worse outcomes following hip arthroscopy in a large SR involving 9,317 patients. (*Levy, 2016*) BMI <25 showed much better outcomes in a cohort study already discussed above. (*Ladd, 2016*)

**Dysplasia or Osteoarthritis:**

An SR of 15 studies/1,195 hip arthroscopies with signs of osteoarthritis showed that patients with Tonnis grade 1 or higher or a joint space of  $\leq 2$  mm were less likely to benefit and more likely to require subsequent arthroplasty. (*Domb, 2015*) A cohort of 154 Tonnis grade 1 compared to 738 Tonnis grade 0 hip arthroscopic patients with minimum 2-year follow-up revealed no major difference in outcomes. (*Chandrasekaran, 2016a*) However, the same authors separately reported that within the same cohort, 43 additional patients with more advanced Tonnis grade 2 OA had significantly higher rates of conversion to total hip arthroplasty, suggesting limited effectiveness for arthroscopy in this subgroup. (*Chandrasekaran, 2016b*)

An SR of 18 studies/889 patients undergoing hip arthroscopy with the presence of hip dysplasia reported over 14% revision rates, but there was great variation in the criteria

defining dysplasia. (Yeung, 2016) A more narrowed SR of 10 studies/834 hips with definite dysplasia reported improved outcomes for “borderline” cases but suggested periacetabular osteotomy (PAO) for true dysplasia. (Lodhia, 2016) Similar success with borderline dysplasia was seen in 102 hips arthroscopically treated for labral repair/FAI. (Fukui, 2015)

### **Revision arthroscopy:**

One SR of 348 revision hip arthroscopies performed primarily for “residual” FAI noted clinical improvement with only a 5% reoperation rate at 2 years. (Cvetanovich, 2015) Another cohort of 107 arthroscopic revisions resulted in 11.2% conversion to arthroplasty at 2 years, double the rate of their primary cases. (Domb, 2016) A much less optimistic SR with 448 hips undergoing revision arthroscopy for FAI, labral tears, and chondral lesions noted some success, but outcomes were clearly inferior to primary hip arthroscopic procedures. The reoperation rate was 14.6% within 1-2 years, and all available articles were deemed “low-quality evidence.” (Sardana, 2015) Even worse, a prospective series of 70 revision hip arthroscopies reported a 25% failure rate at 2 years, with over 21% requiring further surgery. (Gupta, 2016b) Another cohort of 85 relatively young (mean 29.5 years) hips following revision arthroscopy for residual FAI were compared to 237 primary surgeries, with only 63% success vs. 82%, respectively, at 2 years. (Larson, 2014) Because primary arthroscopic FAI surgery still lacks sufficient evidence for broad recommendation and because revision arthroscopy has even less reliable published evidence (with up to 37% failure at 2 years), *revision FAI surgery is not recommended*. Revision arthroscopic capsular repair may be reasonable for the 3% (33/1100) incidence of symptomatic instability following primary hip arthroscopy, since good results have been reported for this specific complication. (Wylie, 2016)

### **Indications for acetabular labrum surgery:**

Labral debridement for small tears, repair for larger tears, and rarely reconstruction for irreparable or previous labral excision (up to 70% of asymptomatic individuals have MRI abnormalities of the labrum, which does not warrant surgery)

- \* Symptomatic acetabular labral tear(s) resulting from a defined injury
- \* Failure of a minimum of 6 weeks conservative treatment, including rest, anti-inflammatory medications, and physical therapy
- \* Persistent mechanical symptoms, including clicking-catching AND/OR locking AND/OR giving way
- \* Physical findings of hip tenderness, pain on extremes of motion, and positive anterior hip impingement test
- \* MRI shows sizable labral tear which correlates with above
- \* Absent or minimal arthritic changes (Tonnis 0 or 1) AND hip joint space >2 mm AND no chondral defects or subchondral cysts
- \* Under age 50

\* BMI <30

\* Pain relief should be demonstrated with a diagnostic intra-articular anesthetic injection in questionable or borderline cases

There are two general types of hip labral tears: degenerative resulting from decades of use and activity, and traumatic injuries, commonly associated with sudden, twisting maneuvers that cause immediate pain in the hip. Labral tears present with anterior hip or groin pain, and less commonly buttock pain. Frequently, there are also mechanical symptoms, including clicking, locking, and giving way. The most consistent physical examination finding is a positive anterior hip impingement test. Early treatments of a hip labral tear should include rest, anti-inflammatory medications, physical therapy, and possibly a corticosteroid injection. If these treatments fail to alleviate the pain and catching associated with a hip labral tear, then a hip arthroscopic procedure may be considered. Surgery usually involves removal of small torn areas of the labrum, with repair for larger lesions. Arthroscopic treatment for acetabular labral tears without hip dysplasia or bony impingement lesions has shown good short- to mid-term results. The best outcome is expected in the absence of synovitis and chondral lesions. Limited, short-term follow-up studies suggest that labral repair/reconstruction/preservation leads to superior outcomes compared with labral debridement/excision. (*Groh, 2009*) (*Haviv, 2011*) (*Larson, 2012*) MRI of asymptomatic individuals having no history of pain, injury, or surgery revealed abnormalities in 73% of hips, with labral tears being identified in 69%. A strong correlation was seen with aging, cartilage defects, and subchondral cysts. This recognition that asymptomatic people have more than a 50% chance of having labral tearing on MRI emphasizes the danger of making clinical decisions to operate solely on the basis of a diagnostic test without other clinical indications. (*Register, 2012*)

#### **Recent research:**

A retrospective analysis of 59 hips following isolated arthroscopic labral debridement resulted in 45% poor outcomes, suggesting concomitant treatment for bony impingement and preservation of the labrum whenever possible. (*Krych, 2014*) A systematic review (SR) including 6 studies/490 patients with femoroacetabular impingement (FAI) also having labral surgery noted generally better clinical outcomes with labral repair compared to labral debridement, but high-quality studies were notably lacking. (*Ayeni, 2014a*) Another SR of 5 studies/128 patients who had labral reconstruction procedures led to recommendation of this relatively new procedure for young patients having no significant arthritis with irreparable tears or previous surgical excision. However, an overall 20% failure rate was also reported. (*Ayeni, 2014b*) Worker's compensation status did not appear to result in much worsening of outcomes following arthroscopic labral surgery, and 86% of individuals were able to return to work. (*Stake, 2013*)

Claimant argued a number of points, none of which were persuasive. Some examples include: Claimant questioned the validity of the ODGs as a whole. He questioned whether the ODG should be considered evidence based medicine. He questioned the IRO process by which the final review is performed by an anonymous physician, which he felt could be a janitor for all he knew. He believed that there was no way to determine whether any physician, much less one with applicable credentials, performed the IRO review. He questioned the necessity of excluding individuals over the age of 50, or whose BMI is over 30.

Claimant did not provide persuasive evidence based medical evidence to challenge the IRO. The affidavit from Dr. S was unpersuasive, and was not convincing to establish through evidence based medical evidence that the decision of the IRO should not be upheld. It developed during the hearing that the affidavit was not created by Dr. S, but by Claimant's attorney, though Dr. S did execute the affidavit in the presence of a notary. Within the affidavit, broad references to Dr. S's opinion, as well as "evidence based medicine" show that Claimant is an excellent candidate for the proposed surgery. No citations to any evidence based medicine are included, and the term is included in quotation marks, which is curious as it is a defined term. The affidavit incorrectly asserts that the only two reasons Claimant's surgery was not authorized was due to his age and BMI, and provides no explanation as to why conservative treatment, as identified in the ODG and each of the preauthorization denials, was not attempted or completed. Finally, the affidavit references that:

The ODG is just one of many guidelines that all claim to be based on "evidence based medicine." Based on other "evidence based medicine" guidelines, including that promulgated by United Health Care (UHC), the largest health care company in the world, (Claimant) has *all* (emphasis in original) the required criteria for the proposed right hip arthroscopy.

The affidavit then goes on to list five criteria, not cited to a specific study or criteria. Claimant's Exhibit 9, admitted at this point, included a highlighted portion of a UHC coverage rationale, identical to those listed in the affidavit. The UHC coverage rationale noted the information pertaining to medical necessity review, which Claimant argued he met. The UHC coverage rationale, however, was not for the proposed surgery of right hip arthroscopy, labral repair vs. debridement, but instead was for femoroacetabular impingement syndrome treatment. Carrier has disputed compensability of femoroacetabular impingement of the right hip in several PLN-11s in evidence. Dr. BS, an orthopedic surgeon testifying on behalf of Carrier, persuasively explained that a labral tear and femoroacetabular impingement are two separate conditions.

Claimant failed to carry his burden of proof to establish that the preponderance of the evidence was contrary to the decision of the IRO. Dr. S did not provide the necessary medical evidence to the IRO to support his opinion that Claimant met the ODGs for the proposed surgery.



Specifically, no evidence was presented at any level of review, including this CCH, that Claimant failed a minimum of 6 weeks conservative treatment, that Claimant had persistent mechanical symptoms, an MRI showing sizable labral tear, or that he had pain relief from a diagnostic intra-articular anesthetic injection. The decision of the IRO is supported by the preponderance of the evidence, including the medical records entered into evidence at this CCH, as well as the testimony of Dr. S.

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. The Texas Department of Insurance, Division of Workers' Compensation has jurisdiction to hear this matter.
  - B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
  - C. On (Date of Injury), Claimant was the employee of (Employer), Employer.
  - D. On (Date of Injury), Employer provided workers' compensation insurance coverage through Texas Mutual Insurance Company, Carrier.
  - E. On (Date of Injury), Claimant sustained a compensable injury.
  - F. The compensable injury of (Date of Injury), extends to and includes a low back strain and right (hip) acetabular labrum tear.
  - G. The Independent Review Organization determined Claimant should not have the requested treatment of right hip arthroscopy, labral repair vs. debridement.
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. A right hip arthroscopy, labral repair vs. debridement is not health care reasonably required for the compensable injury of (Date of Injury).
4. The preponderance of the evidence is not contrary to the decision of the Independent Review Organization.

## 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, and Claimant is not entitled to right hip arthroscopy, labral repair vs. debridement.

## DECISION

Claimant is not entitled to the requested right hip arthroscopy, labral repair vs. debridement.

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

**RICHARD GERGASKO, PRESIDENT  
6210 EAST HIGHWAY 290  
AUSTIN, TEXAS 78723**

Signed this 5<sup>th</sup> day of September, 2018.

Amber Morgan  
Administrative Law Judge