MEDICAL CONTESTED CASE HEARING NO. 19011

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 determined that: (1) the Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case and determine whether the preponderance of the evidence is contrary to the decision of the Independent Review Organization (IRO) that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery; (2) the preponderance of the evidence is not contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery; (4) Claimant/Petitioner did not timely appeal the IRO decision; and (5) Insurance Carrier/Respondent is not liable for payment of the right open biceps tenodesis surgery in accordance with 28 Texas Administrative Code (TAC) §134.600(c).

STATEMENT OF THE CASE

On August 28, 2019, Kara Squier, a Division administrative law judge, held a contested case hearing to decide the following disputed issues:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery?
>
> Did the Claimant/Petitioner timely appeal the IRO decision?
>
> Does the Division have jurisdiction to determine whether the preponderance of the evidence is contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery?

To reflect the issues actually litigated by the parties, Issue Number 4 was added as follows:

1. Is Insurance Carrier/Respondent liable for payment of the right open biceps tenodesis surgery in accordance with 28 TAC §134.600(c)?

Following the hearing, the undersigned reopened the record to notify the parties that Issue Number 4 was added to reflect the issues actually litigated during the hearing. The parties were provided an additional opportunity to object or provide further responses, and the record closed on September 9, 2019.

PARTIES PRESENT

Claimant/Petitioner appeared and was assisted by CT, ombudsman. Insurance Carrier/Respondent appeared and was represented by LW, attorney.

DISCUSSION

It is undisputed that Claimant/Petitioner sustained a compensable injury on (Date of Injury). Claimant/Petitioner's orthopedic surgeon, JP, M.D., requested preauthorization on January 23, 2019, for a right open biceps tenodesis surgery. On January 25, 2019, the utilization review agent, GS, D.O., sent out a decision in which he determined the requested surgery was not medically necessary in accordance with the Official Disability Guidelines (ODG). Dr. P submitted a second pre-authorization request on January 28, 2019. On February 1, 2019, the second utilization review agent, GG, M.D., submitted a denial indicating the requested surgery was not medically necessary in accordance with the ODG.

Dr. P performed the requested surgery on February 15, 2019, and Claimant/Petitioner requested a review by an independent review organization (IRO) on March 17, 2019. The IRO reviewer upheld the previous denials, and Claimant/Petitioner appealed by requesting a medical contested case hearing on June 11, 2019.

Timeliness of Appeal and Jurisdiction

28 TAC §133.308(s)(1)(A) states, to wit:

> The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

In this particular case, the IRO decision was issued and sent to the parties on April 15, 2019. The applicable deadline for the filing of the appeal of the IRO decision in this case was 20 days from the date the IRO decision was sent to the parties. Both parties offered a request to schedule a medical contested case hearing signed on June 11, 2019, and the evidence established the request was received on that date. Considering the IRO decision is dated April 15, 2019, Claimant/Petitioner's request to schedule a medical contested case hearing was not timely. However, an assertion, or finding, that an appeal is untimely under 28 TAC §133.308 does not deprive the Division of subject matter jurisdiction to decide the disputed issue. The untimeliness

of the appeal is a defense to the insurance carrier's ultimate liability for the services or bill in question. *See* Medical Contested Case Hearing Decision No. 09122, M6-09-13618-01, citing *Igal v. Brightstar Info. Technology Group, Inc.*, 250 S.W.3d 78 (Tex. 2008); *see also Dubai Petroleum Co. v. Kazi*, 12 S.W.3d 71 (Tex. 2000); and *City of Seabrook v. Port of Houston Auth.*, 199 S.W.3d 403 (Tex. App.-Houston [1st Dist.] 2006, pet. abated).

Medical Necessity

Texas Workers' Compensation Act: Texas Labor Code §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 Labor Code §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 Labor Code §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. Labor Code §413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Labor Code §413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by 28 TAC §137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be health care reasonably required as defined in the Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with 28 TAC §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 right open biceps tenodesis surgery:

> Recommended (tenodesis) for advanced biceps tendinopathy, subluxation/dislocation, or rupture under age 55 (tenotomy/debridement > 55); may be considered in patients over

35 with type II or IV SLAP lesions when other criteria are met and biceps specific symptoms are documented.

Criteria for Surgery for Biceps tenodesis (or tenotomy):

- History, physical examination, and imaging indicate significant shoulder biceps tendon pathology or rupture
- After 3 months (6 months for isolated type II SLAP lesions) of failed conservative treatment (NSAIDs, injection, and PT) unless combined with acute rotator cuff repair
- An alternative to direct repair for type II SLAP lesions (fraying, some detachment) and type IV (> 50% of biceps tendon involved, vertical or bucket-handle tear of the superior labrum, extending into biceps)
- Generally, type I and type III SLAP lesions do not need any treatment
- Age > 35 with Type II and IV SLAP tears (younger optional if overhead throwing athlete)
- Age < 55 for non-SLAP biceps pathology, especially with concomitant rotator cuff repair; tenotomy is more suitable for older patients (past age 55)

Risk versus Benefit: Compared with primary SLAP repair, risks are lower with tenotomy or tenodesis. Complications of tenotomy are mild and include cosmetic deformity, residual pain or achiness, and slight strength deficit for elbow flexion and forearm supination. Patient satisfaction over 90% can still be expected following tenotomy with mild and/or infrequent reports of cosmetic deformity (13%), occasional cramping (19%), and subjective weakness (17%), mostly in men. Satisfaction is remarkably high for tenotomy, especially for females and middle-age or older individuals. Tenodesis complications can include failure of fixation resulting in cosmetic deformity and/or residual pain, stiffness, infection, hematoma, neurologic or vascular injury, fracture, and complex regional pain syndrome (CRPS). Tenodesis in young (avg. age 38) active duty military resulted in only 5% complications and less than 1% failures requiring revision.

Biceps tenodesis (suture of the end of the tendon to the bone) is a surgical procedure sometimes performed for refractory biceps tendonitis of the shoulder. Tenodesis may be performed as an isolated procedure, or as part of a larger shoulder surgery such as a rotator cuff repair. There can be a partial detachment of the biceps tendon from the socket of the shoulder (SLAP tear), or simply advanced inflammation and irritation of the biceps tendon itself. Tenodesis is more commonly performed in patients over age 40, whereas other procedures like direct SLAP repair may be more appropriate for younger patients. Individuals older than 35 years with an isolated type II SLAP lesion had a shorter postoperative recovery, a more predictable functional outcome, and higher rate of

satisfaction and return to activity with tenodesis compared to direct biceps repair. These authors concluded that biceps tenodesis is preferable to biceps repair for isolated type II SLAP lesions in non-overhead athletes older than 35. (*Denard, 2014*)

Direct surgical repair has been a gold standard for most type II and type IV SLAP lesions that fail nonoperative management. However, more recent reports have demonstrated unacceptably high failure rates following primary repair of type II SLAP lesions. Biceps tenodesis may also offer an acceptable, if not better alternative to primary repair of many SLAP lesions. (*Gottschalk, 2014*) Biceps tenodesis is a viable proven treatment option for SLAP repair. (*Huri, 2014*) Successful arthroscopic repair of symptomatic superior labral tears in young athletes has been well documented. But, superior labral repair in patients older than 40 years is controversial, with concerns for residual postoperative pain, stiffness, and higher rates of revision surgery. While studies demonstrate that good outcomes can be obtained with SLAP repair in some older cohorts of patients, age over 40 and workers' compensation status are independent risk factors for increased surgical complications. It was concluded that the cumulative evidence is more supportive of labral debridement or biceps tenotomy over direct labral repair when an associated rotator cuff tear is present. (*Erickson, 2014*) Practice trends indicate that the proportion of SLAP repairs has decreased over time, with an increase in biceps tenodesis and tenotomy. Increased patient age correlates with more likelihood of treatment with biceps tenodesis or tenotomy, replacing SLAP repair. For patients with isolated SLAP lesions, the proportion of SLAP repairs decreased from 69.3% to 44.8%, while biceps tenodesis increased from 1.9% to 18.8%, and biceps tenotomy increased from 0.4% to 1.7%. For patients undergoing concomitant rotator cuff repair, SLAP repair decreased from 60.2% to 15.3% (often simple labral debridement), while biceps tenodesis or tenotomy increased from 6.0% to 28.0%. There was a significant difference in the mean age of patients undergoing SLAP repair (37.1 years) versus biceps tenodesis (47.2 years) versus biceps tenotomy (55.7 years). (*Patterson, 2014*)

Another U.S. analysis of almost 45,000 biceps tenodesis procedures reported yearly increases almost doubling since 2008, with significant regional variations in incidence. (*Werner, 2015*) A national insurance database of almost 30,000 rotator cuff repairs (RCR) including over 6,300 having concomitant biceps tenodesis (arthroscopic and open) was analyzed for subsequent re-operation rates. Significantly more patients required repeat surgery by 6 months and 1 year who had also had biceps tenodesis. The tenodesis group also had higher dislocation, nerve injury, and surgical site infection rates. (*Erickson, 2017*) A randomized controlled trial (RCT) of 129 rotator cuff repair patients divided to debridement, tenodesis, or tenotomy groups, demonstrated equally effective improvements in pain and function regardless of technique. Debridement resulted in the lowest occurrence of Popeye deformity, which was reported in only *37% of tenotomy* and *26% of tenodesis* patients. Tenodesis was recommended primarily for males who needed

to specifically preserve supination strength. (*Oh, 2016*) Another RCT comparing 151 rotator cuff repair patients older than age 55 noted equal outcomes with associated tenodesis or tenotomy, but shorter surgical time and faster pain relief with tenotomy, suggesting more suitability for older patients. (*Zhang, 2015*) A systematic review/meta-analysis (SR/MA) of 9 studies and 650 patients, mostly having concomitant shoulder pathology, compared outcomes of tenodesis vs. tenotomy, with no significant differences in functional scores, elbow flexion, or supination strength between groups. Popeye deformity and temporary cramping occurred somewhat more frequently with tenotomy. (*Gurnani, 2016*) An RCT of 128 tenodesis and tenotomies also showed no significant differences in functional scores but a 3-times higher incidence of Popeye deformity with tenotomy. Interestingly, 80% of tenotomy patients did not have the cut end of the tendon retract distal to the bicipital groove on MRI at 12 months. (*Lee, 2016*) Most studies comparing tenodesis to tenotomy are limited to lower level evidence and have confounding factors such as other concomitant shoulder procedures and surgeon preferences, suggesting a need for more high-powered studies. (*Patel, 2016*) Biceps tendinopathy is commonly associated with other shoulder pathologies, and persistent shoulder symptoms following tenodesis is commonly related to missed or untreated lesions. Tenodesis should be reserved for younger, high-demand patients since it requires more rehabilitation time and has a higher cost. (*Mellano, 2015*)

Complications of tenotomy are mild and include cosmetic deformity, residual pain or achiness, and slight strength deficit for elbow flexion and forearm supination. Tenodesis complications include failure of fixation resulting in cosmetic deformity and/or residual pain, stiffness, infection, hematoma, neurologic or vascular injury, fracture, and complex regional pain syndrome (CRPS). (*Virk, 2016*) A large (166 patients) retrospective series of unicortical suture button tenodesis in young (avg. age 38) active duty military resulted in only 5% complications and less than 1% failures requiring revision. (*Cook, 2017*) A patient satisfaction analysis of 104 tenotomy patients reported 91-95% overall satisfaction with mild and/or infrequent reports of cosmetic deformity (13%), occasional cramping (19%), and subjective weakness (17%), mostly in men. Satisfaction is quite high, especially for females and middle-age or older individuals. (*Meeks, 2017*)

Surgical tenodesis techniques: 46 patients had either open or arthroscopic long head tenodesis with similar pain relief and clinical outcomes. (*Gombera, 2015*) An RCT of 80 patients compared outcomes of suture anchor or interference screw (IS) fixation over 2 years, with similar functional results, except for a significantly higher fixation failure rate for IS, especially for workers with more physically demanding work levels. *(Park, 2017)* 211 patients had either arthroscopic keyhole or IS techniques with less pain, visible deformity, distal tendon migration, as well as fewer complications and less cost using keyhole fixation. (*Kany, 2016*) Another cost-effective, reliable, and innovative method of arthroscopic biceps tenodesis involves a lasso-loop attachment to the antero-medial

footprint rotator cuff repair suture anchor, requiring no additional anchors or secondary surgical scars. (*Uschok, 2016*)

Claimant/Petitioner testified concerning the mechanism of injury and his course of treatment; however, a qualified expert medical opinion with reference to evidence-based medicine was necessary for Claimant/Petitioner to meet his burden of proof on this matter and such evidence-based medical evidence was lacking in this case. As such, insufficient evidence-based medical evidence existed to explain that the requested surgery was health care reasonably required for the compensable injury. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that Claimant/Petitioner is not entitled to right open biceps tenodesis surgery.

Insurance Carrier Liability

Pursuant to 28 TAC §134.600(c), the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:
   - (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   - (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
   - (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
   - (D) when ordered by the commissioner;

(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

The requested surgery is non-emergency health care that required preauthorization pursuant to 28 TAC §134.600(p). Considering Claimant/Petitioner did not obtain preauthorization prior to receiving the surgery, Insurance Carrier/Respondent is not liable for the surgery. Moreover, as previously mentioned, the decision of the IRO is upheld and the surgery is not considered reasonable and medically necessary.

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. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   B. On (Date of Injury), Employer provided workers' compensation insurance through New York Marine & General Insurance Company, Insurance Carrier.

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

2. Insurance Carrier/Respondent delivered to Claimant/Petitioner a single document stating the true corporate name of Insurance Carrier/Respondent, and the name and street address of Insurance Carrier/Respondent's registered agent, which document was admitted into evidence as Administrative Law Judge's Exhibit Number 2.

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

4. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

5. Right open biceps tenodesis surgery is non-emergency health care that requires pre-authorization pursuant to 28 TAC §134.600(p).

6. Dr. P requested pre-authorization for a right open biceps tenodesis surgery that went to utilization reviews on January 25, 2019, and February 1, 2019, and the requests were denied as not medically necessary.

7. Dr. P performed the right open biceps tenodesis surgery on February 15, 2019.

8. Claimant requested a review by an IRO on March 17, 2019.

9. The IRO decision is dated April 15, 2019, and the IRO reviewer upheld the previous denials.

10. Claimant/Petitioner's appeal of the IRO decision was filed on June 11, 2019, not within the 20-day deadline contained in 28 TAC §133.308(s)(1)(A).

11. A right open biceps tenodesis surgery 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 and determine whether the preponderance of the evidence is contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery.

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

3. The preponderance of the evidence not contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery.

4. Claimant/Petitioner did not timely appeal the IRO decision.

5. Insurance Carrier/Respondent is not liable for payment of the right open biceps tenodesis surgery in accordance with 28 TAC §134.600(c).

DECISION

The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case and determine whether the preponderance of the evidence is contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery. The preponderance of the evidence not contrary to the decision of the IRO that the Claimant/Petitioner is not entitled to right open biceps tenodesis surgery. Claimant/Petitioner did not timely appeal the IRO decision. Insurance Carrier/Respondent is not liable for payment of the right open biceps tenodesis surgery in accordance with 28 TAC §134.600(c).

ORDER

Insurance Carrier/Respondent is not liable for the benefits at issue in this hearing. Claimant/Petitioner remains entitled to medical benefits for the compensable injury in accordance with Labor Code § 408.021.

The true corporate name of the insurance carrier is **NEW YORK MARINE & GENERAL INSURANCE COMPANY,** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3218

Signed this 12th day of September, 2019.

Kara Squier
Administrative Law Judge