

MEDICAL CONTESTED CASE HEARING NO. 14058

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.

ISSUE

A contested case hearing was held on April 2, 2014 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 a right shoulder arthroscopy with rotator cuff repair and biceps tenodesis for his compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant appeared and was assisted by LS, ombudsman.
Respondent/Carrier appeared and was represented by CA, adjustor.
Petitioner did not attend the hearing other than during his testimony.

BACKGROUND INFORMATION

Claimant sustained a shoulder injury as the result of a fall, and underwent surgery to treat his injury. His current health care provider has now recommended that Claimant undergo the proposed additional surgery.

KB, M.D. , Claimant's current surgeon, testified that he began treating Claimant in September of 2012, and that an MRI study performed approximately one month thereafter revealed a rotator cuff tear and biceps subluxation which could be successfully addressed by performing the surgical procedure that he has proposed. He indicated that while he is unaware of the overall success rate of the proposed surgery, it is generally accepted by the medical community and he, personally, has experienced no failures out of the twenty to thirty such procedures that he has performed.

In Dr. B opinion, the proposed surgery would reduce Claimant's pain while increasing his functionality, and Claimant's age was not a factor in the anticipated success of surgery, since Claimant had not experienced a complete rupture of the anatomical structure to be repaired. The witness further stated that the surgery was recommended by the ODG, and that the IRO had made erroneous statements that affected the reliability of its decision.

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 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."

With regard to the proposed rotator cuff repair, the ODG reads as follows:

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. 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 degeneration to full

avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically 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) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about 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 to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)

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)

Recent research: Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse,

patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of 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 found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no difference in health-related quality of life, function, pain, range of motion, and strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers' compensation status, and duration of symptoms usually did not predict poorer outcomes. (Seida, 2010) "Rotator cuff surgery is a viable option for many patients, but, as with any surgery, it is not for everybody," said AHRQ Director CM C, M.D. "This report has good news: most interventions work, and each patient should talk to his or her doctor about which to option to pursue." Most older patients who suffer a rotator cuff tear are first treated with up to 3 months of nonsurgical treatment such as pain and anti-inflammatory medications, exercise, and rest. If treatments other than surgery do not work, the rotator cuff may be repaired surgically, using a variety of methods ranging from minimally invasive techniques to an open operation. Patients can then undergo rehabilitation to restore their range of motion, muscle strength, and function following surgery. Rotator cuff tears also can occur in younger adults, usually as a result of traumatic injury. In such cases they are almost always treated with surgery. Some doctors have maintained that earlier surgery results in less pain and better use of the

shoulder, leading to an earlier return to work and decreased costs; so, patients often face the difficult decision of opting for surgery rather than waiting for nonoperative treatments to work. However, researchers found little evidence that earlier surgery benefits patients. Comparative Effectiveness of Nonoperative and Operative Treatments for Rotator Cuff Tears is the newest comparative effectiveness report from the AHRQ's Effective Health Care Program. The Effective Health Care Program represents the leading federal effort to compare alternative treatments for health conditions and make the findings public, to help doctors, nurses, pharmacists and others work together with patients to choose the most effective treatments. (Clancy, 2010) This prospective cohort study concluded that PT is effective for most patients with atraumatic full-thickness rotator cuff tears and shoulder pain, without the need for surgery. At six weeks fewer than 10% of patients had decided to undergo surgery, and after 2 years, only 2% of the rest had opted for surgery. Patients did most of their physical therapy at home and usually made only 1 weekly visit to the physical therapist. (Kuhn, 2011) One-third of rotator cuff repairs fail, and 74% of the failures occur within three months of surgery. Healed tendons, or recurrent tears, at six months can predict outcomes at seven years. (Kluger, 2011) Not surprisingly, larger tears are harder to repair, and the retear 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 efficacy in operative or nonoperative treatment of rotator cuff tears in in patients aged older than 60 years. (Downie, 2012)

ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of 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:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
- (3) **Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

- (1) **Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
 - (2) **Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
 - (3) **Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign 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 Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.
- (Washington, 2002)

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

With regard to tendon repair surgery, the ODG states:

Not recommended except as indicated below. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. (Mazzocca, 2008) (Chillemi, 2007) Ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively, since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. (Rantanen, 1999) When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. In tenodesis, the surgeon cuts the normal attachment of the biceps tendon on the shoulder socket and reattaches it to the humerus. This maneuver takes pressure off the cartilage rim of the shoulder socket (the labrum), and a portion of the tendon can be resected. The alternative, a tenotomy, simply involves cutting and suturing the tendon. With tenodesis, patients have a longer recovery, but they're also more likely to have better function and a normal appearing biceps muscle. With tenotomy, there can be arm cramping, weakness, and a biceps tendon abnormality called a "Popeye deformity". Tenodesis is a better approach except for the aged, senile, and less active. (Koh, 2010)

ODG Indications for Surgery™ -- Ruptured biceps tendon surgery:

Criteria for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of *incomplete tear or fraying of the proximal biceps tendon* (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):

- (1) **Subjective Clinical Findings:** Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS
- (2) **Objective Clinical Findings:** Partial thickness tears do not have classical appearance of ruptured muscle. PLUS
- (3) **Imaging Clinical Findings:** Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for tenodesis of long head of biceps with diagnosis of *complete tear of the proximal biceps tendon*: Surgery almost never considered in full thickness ruptures. Also required:

- (1) **Subjective Clinical Findings:** Pain, weakness, and deformity. PLUS
- (2) **Objective Clinical Findings:** Classical appearance of ruptured muscle.

Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.

(Washington, 2002)

In order to prevail, Claimant must show one of three things: that his proposed treatment is consistent with the ODG, that evidence-based medicine exists that is more persuasive than the ODG, or that the requested treatment is not addressed by the ODG. The Hearing Officer's comparison of the ODG criteria with Claimant's medical records indicates that the proposed treatment does comport with the mandatory components of the relevant ODG criteria, although it does not meet the recommended surgical selection criteria listed in the ODG. Specifically, it is noted that that the ODG *recommends*, but does not *require*, that a candidate for revision rotator cuff surgery be under sixty years of age and have preoperative

elevation above the shoulder, thereby indicating that although the proposed treatment is consistent with a strict reading of the language of the ODG, studies have shown that it is less likely to be successful than it might be under optimal circumstances. Consequently, a decision in favor of Petitioner will be entered as to the sole issue presented for resolution herein.

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. On (Date of Injury), Claimant was the employee of (Employer), Employer.
2. On (Date of Injury), Employer subscribed to workers' compensation insurance coverage through the Federal Insurance Company, Carrier.
3. On (Date of Injury), Claimant's residence was located within seventy-five miles of the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
4. Carrier delivered to Claimant/Petitioner 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 Hearing Officer's Exhibit Number 2.
5. A right shoulder arthroscopy with rotator cuff repair and biceps tenodesis is health care reasonably required for Claimant's 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 contrary to the decision of the IRO that a right shoulder arthroscopy with rotator cuff repair and biceps tenodesis is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is entitled to a right shoulder arthroscopy with rotator cuff repair and biceps tenodesis for his compensable injury of (Date of Injury).

ORDER

Carrier is 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 carrier is **FEDERAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is:

**CT CORPORATION SYSTEM
1999 BRYAN STREET, #900
DALLAS, TEXAS 75201**

Signed this 14th day of April, 2014.

Ellen Vannah
Hearing Officer