MEDICAL CONTESTED CASE HEARING NO. 16007

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence-based medical evidence is contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to a right shoulder rotator cuff repair and subacromial decompression, since this surgery has been shown to be health care reasonably required for the Claimant's compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on November 17, 2015 to decide the following disputed issue:

> Is the preponderance of the evidence-based medical evidence contrary to the decision of the IRO that the claimant is not entitled to a right shoulder rotator cuff repair and subacromial decompression for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by LR, ombudsman. Respondent/Carrier appeared and was represented by JV, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Petitioner/Claimant:

1. DP, Petitioner/Claimant
2. Dr. JW (by telephone)

For Respondent/Carrier:

None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibit HO-1 and HO-2

Petitioner/Claimant's Exhibits C-1 through C-7

Respondent/Carrier's Exhibits CR-1 through CR-7

DISCUSSION

It was undisputed that the Claimant sustained a compensable right shoulder injury on (Date of Injury) while working for the (Employer). The Claimant, who is right-handed, was diagnosed by Dr. RB of the Fondren Orthopedic Group with a right shoulder rotator cuff tear. Dr. B performed the first surgery on the Claimant on August 22, 2013, which consisted of a right shoulder arthroscopic rotator cuff repair and subacromial decompression. Thereafter, an arthrogram performed on the Claimant's right shoulder on April 21, 2014 showed recurrent full-thickness tears of the supraspinatus and infraspinatus tendons with retraction to the glenohumeral joint. Dr. B performed a second surgery on the Claimant's right shoulder on May 23, 2014, which consisted of an arthroscopic revision rotator cuff repair and subacromial decompression. The Claimant, whose testimony was very credible, testified at this hearing that neither of these surgeries improved her condition, and that she continues to have constant, severe right shoulder pain. After the second surgery, because of the Claimant's continued symptoms, Dr. B referred the Claimant to one of his associates, Dr. JW, who also is with the Fondren Orthopedic Group. Dr. W first saw the Claimant on March 17, 2015, and he had an MRI performed on the Claimant's right shoulder on that date that showed a recurrent rotator cuff tear. Dr. W thereafter requested the third surgery that is the subject of this dispute.

The request herein for a third right rotator cuff repair and subacromial decompression was denied by two of the Carrier's utilization review agents (URAs). The denials were upheld by an IRO. The IRO physician reviewer who, like Drs. B and W, is an orthopedic surgeon, bases the decision on medical judgment and not on the *Official Disability Guidelines* (ODG), since the ODG recommends rotator cuff surgery, including revision surgery, if the criteria are met. The IRO physician reviewer has opined that the Claimant is at high risk for further complications with a third attempt at a rotator cuff repair and noted that Dr. W does not state in his records that there is a likelihood that a third repair would be successful. The IRO physician reviewer also noted that Dr. W does not mention in his records that consideration has been given to doing a graft jacket type repair, nor do his records state that he has any extensive experience in salvaging prior failed rotator cuff repairs. Finally, the IRO physician reviewer stated that since the current clinical literature does not provide sufficient evidence regarding the efficacy of salvage-type rotator cuff repairs as it relates to overall functional improvement or pain relief, the IRO physician reviewer is of the opinion that the medical necessity for a third surgery has not been established.

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 in making decisions about the care of individual patients. 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."

The ODG addresses the medical necessity of surgery for a rotator cuff repair, including a revision rotator cuff repair, 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 Carolyn M. Clancy, 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) In this RCT, full-thickness rotator cuff repair outcomes were the same, with or without acromioplasty. Acromioplasty is commonly performed during arthroscopic rotator cuff repair, but it does not improve outcomes by 2-year follow-up. (Abrams, 2014) Non-contrast MRI is sufficient for rotator cuff tears, and contrast enhancement is recommended for SLAP tears. (Spencer, 2013) (Farshad-Amacker, 2013) (Arnold, 2012) (Major, 2011) See also Stem cell autologous transplantation (shoulder).

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 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 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).

Dr. W's testimony at this hearing was very persuasive and it, along with other evidence, shows that the criteria listed in the ODG for the rotator cuff surgery at issue in this case is met. Dr. W testified that in his practice, which focuses upon shoulder and elbow treatment only, he does approximately 180 rotator cuff repair surgeries annually, with several of them being revision surgery. He testified that there is medical literature that shows that revision rotator cuff repairs can be successful, and that in the last year, he has done two third-revision rotator cuff repair surgeries, one of which was successful, and the other was moderately successful. He testified that there is a chance of success by performing the requested surgery upon the Claimant. He testified that the "graft jacket" that the IRO referred to is a brand name for one of the graft products used in this type of surgery, and that his surgery upon the Claimant would indeed include a graft, specifically pig tissue. He testified that a graft adds a layer to the patient's tissue to help keep it sewed down. He testified that grafting is a "last ditch effort" – once it is done, it cannot be done again, and that neither of the Claimant's first two surgeries used a graft. Dr. W testified that based upon his experience and judgment, his examinations of the Claimant and his review of her medical records, the disputed surgery is medically necessary for the Claimant, because she has exhausted conservative treatment, and she has weakness, severe pain and loss of range of motion that affect her ability to engage in activities of daily living. He testified that the Claimant should not be left in her current condition, given her young age, and that her shoulder is essentially paralyzed since she cannot raise her right arm, which is disabling and will

ultimately lead to the need for a shoulder replacement surgery if not repaired. After a careful review of the entire record, it is determined that the evidence establishes that the preponderance of the evidence-based medical evidence is contrary to the IRO decision. For the reasons stated, it is, therefore, determined that the record establishes that the requested rotator cuff surgery and subacromial decompression is health care reasonably required for the compensable (Date of Injury) injury.

The Hearing Officer 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 had workers' compensation insurance coverage through self-insurance through the State Office of Risk Management.

   D. On (Date of Injury), the Claimant sustained a compensable right shoulder injury while in the course and scope of her employment with (Employer).

2. The right shoulder rotator cuff repair and subacromial decompression has been shown to be health care reasonably required for the Claimant's compensable (Date of Injury) injury.

3. The Carrier delivered to Claimant a single document stating the true corporate name of the Carrier, and the name and street address of the Carrier's registered agent, which was admitted into evidence as Hearing Officer's Exhibit Number 1.

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-based medical evidence is contrary to the decision of the IRO that the Claimant is not entitled to a right shoulder rotator cuff repair and subacromial decompression for the compensable injury of (Date of Injury), since the right shoulder rotator

cuff repair and subacromial decompression have been shown to be health care reasonably required for the Claimant's compensable (Date of Injury) injury.

DECISION

The Claimant is entitled to a right shoulder rotator cuff repair and subacromial decompression for the compensable injury of (Date of Injury).

ORDER

The Carrier is **ORDERED** to pay medical benefits in accordance with this decision, the Act and the implementing Rules.

The true corporate name of the Carrier is **STATE OFFICE OF RISK MANAGEMENT,** and the name and address of its registered agent for service of process is

STEPHEN S. VOLLBRECHT
Mailing address:
P.O. BOX 13777
AUSTIN, TX 78711-3777

Physical address:
300 W. 15TH STREET, 6TH FLOOR
AUSTIN, TX 78701

Signed this 30th day of November, 2015.

Patrice Fleming-Squirewell
Hearing Officer