

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.

ISSUES

A contested case hearing was held on March 24, 2010, to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts are not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by IE, ombudsman.
Respondent/Carrier appeared and was represented by CF, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable injury to her right shoulder on _____ when she was pulling a dolly full of milk gallons over a curb and felt a pop in her right shoulder. Claimant was initially treated at (Healthcare Provider) where she was diagnosed with a right shoulder strain. On July 30, 2009, Claimant underwent an MRI of the right shoulder which revealed no rotator cuff tears but evidence of intracapsular biceps tendinopathy. Claimant was referred to Dr. N, an orthopedic surgeon, who diagnosed impingement syndrome. Dr. N recommended a right shoulder arthrogram which was performed on October 16, 2009 and revealed no full thickness rotator cuff tear, no Hill-Sachs or Bankart lesion and no unstable labral tear. The biceps tendon anchor was reported as normal. Claimant's surgeon has recommended a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shift. This request was denied by the Carrier and referred to an IRO.

The IRO reviewer, a board certified orthopedic surgeon, determined that the proposed procedure was not medically necessary. The IRO reviewer referenced the Official Disability Guidelines (ODG) and noted that it was unclear why the Claimant had not returned to work since there was no specific physical deficit which would have precluded it. Regarding the biceps tendon repair, the IRO stated that, based on the documentation, the Claimant has an unclear diagnosis and that there are no clear documented findings that the Claimant had recurrent dislocation or subluxation and that there was no mention of the Claimant's overall constitutional laxity since the MRI noted a normal biceps anchor. The IRO reviewer noted that the Claimant was reported to have undergone steroid injections without success which is a poor prognostic indicator for shoulder dislocation surgery and the she had no evidence of behavioral evaluation despite a protracted course. The IRO reviewer concluded that there was no evidence of an adequate trial of conservative treatment as recommended in the ODG before consideration for surgery for

impingement syndrome, that the diagnosis is not clear and the pain generators had not been defined; therefore, the request does not meet the criteria as outlined by the ODG.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (t), "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 requested procedures, the ODG provides as follows:

Surgery for ruptured biceps tendon (at the shoulder): 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)

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.

Surgery for impingement syndrome: is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007) Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007) A prospective randomized study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial

impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009) A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. (Ketola, 2009)

ODG Indications for Surgery™ -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of 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. 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 impingement.

Surgery for shoulder dislocation: The available evidence supports primary surgery for young adults, usually male, engaged in highly demanding physical activities who have sustained their first acute traumatic shoulder dislocation (glenohumeral joint). There is no evidence available to determine whether non-surgical treatment should not remain the prime treatment option for other categories of patient (i.e., for patient categories at lower risk of activity-limiting recurrence). (Handoll-Cochrane, 2004) (Gibson, 2004) Multiple traumatic shoulder dislocations of the glenohumeral joint indicate the need for surgery if they limit functional ability and if muscle strengthening fails. Rates of instability recurrence after surgery have been reported as 12% after open repair for anterior instability and 23% after arthroscopic anterior repair. (Sperber, 2001) (Jorgensen, 1999) Shoulder instability is classified as either traumatic or atraumatic based on the mechanism of injury. Traditional treatment for both forms of instability involves a nonsurgical approach, consisting of immobilization, rehabilitation, and a delay in the return to vigorous activities. This treatment is often quite successful in preventing recurrent dislocations in the patient with atraumatic instability. However, those patients with traumatic instability often experience further dislocations or subluxations, with recurrence rates as high as 94% in patients younger than 20 years. Open surgical reconstructions for anterior instability have been reported to be 94-100% successful in preventing recurrence. Arthroscopic stabilization procedures are successful in preventing recurrence in 80-90% of patients and result in low morbidity. However, the most common form of initial treatment for traumatic anterior shoulder instability remains immobilization, supervised rehabilitation, and gradual return to full activity. (Burgess, 2003) This study concluded that arthroscopic repair with suture anchors is an effective surgical technique for the treatment of an isolated Bankart lesion. Open repair does not offer a significantly better 2-year result in terms of stability, and furthermore, can

negatively affect the recovery of full range of motion of the shoulder. (Fabbriciani, 2004) Initial treatment of shoulder subluxation or dislocation is conservative in nature followed by range of motion and strengthening exercises. However, if instability persists either activity modification or surgery may be considered. Activity modifications may be appropriate for those patients who can identify a single motion that aggravates instability, such as overhead throwing motions. Surgical treatment may be considered in those who are unwilling to give up specific activities (i.e., related to sports) or when instability occurs frequently or during daily activities.

ODG Indications for SurgeryTM -- Shoulder dislocation surgery:

Criteria for capsulorrhaphy or Bankart procedure with diagnosis of recurrent glenohumeral dislocations:

1. Subjective Clinical Findings: History of multiple dislocations that inhibit activities of daily living. PLUS

2. Objective Clinical Findings: At least one of the following: Positive apprehension findings. OR Injury to the humeral head. OR Documented dislocation under anesthesia. PLUS

3. Imaging Clinical Findings: Conventional x-rays, AP and true lateral or axillary view. **Criteria** for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS

2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS

3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS

4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

The Claimant testified that she has undergone eight weeks of physical therapy and three injections for treatment of her right shoulder conditions but she has had no relief with any of these conservative treatments. Dr. N testified that, based on the Claimant's physical examination findings, the recommended surgeries are medically necessary. Dr. N testified that the Claimant's condition does not fit in the ODG and that it was unfair to apply the ODG in complicated cases such as the Claimant's. Dr. N testified that the Claimant does not have a ruptured biceps tendon but she does have secondary impingement and instability. Dr. N stated that the ODG are just guidelines and that he was not familiar with the specific criteria for the requested procedures. Dr. N relied on his clinical evaluations and professional experience for recommending the proposed surgeries to the right shoulder. Dr. N did concur with the assessments of the radiologists who interpreted the MRI and the arthrogram but relied on his physical findings in recommending the procedures.

Dr. N was specifically questioned as to the recommendations of the URA doctors and the IRO regarding the medical necessity for the proposed procedures. Dr. N disagreed with applying the ODG treatment guidelines in the Claimant's particular situation. Dr. N offered no other evidence based medicine to support his recommendations. Therefore, the Claimant failed to offer

evidence based medical evidence to establish that the requested treatment which exceeds the ODG recommendations is healthcare reasonably required for the compensable injury. Based on the evidence presented, the Claimant did not meet her burden to present evidence based medicine evidence contrary to the IRO's determination.

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. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
 - B. Claimant sustained a compensable injury on _____, while the employee of (Employer).
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 Hearing Officer's Exhibit Number 2.
3. Claimant failed to show that she meets the criteria under the ODG for a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts.
4. A right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts are not reasonably required medical treatment for the compensable injury of _____.

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 IRO that a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts is not reasonably required medical care for the compensable injury of _____.

DECISION

Claimant is not entitled to a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts for the compensable injury of _____.

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 **ACE AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CT CORPORATION
350 NORTH ST. PAUL STREET
DALLAS, TX 75201**

Signed this 24th day of March, 2010.

CAROL A. FOUGERAT
Hearing Officer