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**DATE OF REVIEW:** JULY 19, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Rotator Cuff (capsule) sprain, Sprain of unspecified site of shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board certified in Orthopaedic Surgery, licensed in the State of Texas, and DWC ADL approved.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Rotator Cuff (capsule) sprain, Sprain of unspecified site of shoulder	29826	Upon approval	Adverse determination overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Record Description	Record Date
MRI results	11/15/06
Office Visit –MD	01/18/07
Progress note –MD	02/12/07
Progress note –MD	03/05/07
Progress note –MD	03/28/07
Utilization review request for left shoulder scope w/bicep tenodesis – MD	04/01/07
Utilization review - denial of left shoulder scope w/bicep tenodesis	04/09/07
Progress note –MD	04/18/07
Utilization review appeal request –MD	05/01/07
Utilization review - appeal of denial –	05/08/07
Progress note –MD	05/08/07
Progress note –MD	05/16/07
Letter regarding denial of surgery –MD	05/16/07
Office Visit – MD	06/13/07
Progress note regarding denial of requested surgery –MD	06/13/07
IRO request –MD	06/18/07

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient presented is a female who alleges a lifting injury to the left shoulder. She has had extensive conservative management for symptoms c/w proximal biceps tendon inflammation or injury, including multiple injections and PT. Although initially suspected of having a RCT, none was found on MRI performed 11/15/06; however, significant abnormality of the proximal biceps tendon was reported, including attenuation and subluxation. Two preauthorization requests for DSA/SAD and proximal biceps tenodesis were non-certified.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Approval recommended for DSA/SAD and proximal biceps tenodesis.

The documentation supports the fact that proximal biceps tendon pathology has been present all along, albeit the exact method of injury remains elusive. Abnormality of the tendon is demonstrated on the MRI. Proximal BT pain often radiates toward the AC joint. The distal clavicle and/or AC joint likely was not injured via lifting; therefore, distal clavicle resection is likely not indicated vis-à-vis potential radiating pain from the biceps tendon. Subluxation of the tendon may indicate an associated proximal subscapularis tendon lesion that may require repair, as well.

ODG criteria are particularly weak in this area. The recommendations appear to cover a wide variety of circumstances, and are even contradictory. The more authoritative source in this instance is OKU, which provides concise statements regarding treatment of biceps tendon lesions.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ODG:

Citation: Not recommended except as indicated below.

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 TM – 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 along 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)

OKU, Shoulder and Elbow 2, AAOS, Chapters 16, 17.

Chapter 16

Other lesions:

Teres minor lesions are well visualized and are repaired with the techniques described above, but the anchors usually must be inserted through a separate posterolateral incision. Subscapularis tears that are limited to the superior 25% may be repaired arthroscopically after the arm is elevated and externally rotated. Full-thickness subscapularis tears are repaired through a separate anterior open deltopectoral approach. Biceps subluxation or dislocation occurs medially through a tear of the superior subscapularis and is stabilized by arthroscopic subscapularis and is stabilized by arthroscopic subscapularis repair. Partial biceps tendon tears greater than 50% are tenodesed arthroscopically.

Chapter 17

Long head of the biceps tenotomy:

At the time of surgery, the intra-articular portion of the biceps can best be evaluated with an arthroscopic examination. Extra-articular evaluation has been described only with open surgery until recently, but it can also be evaluated at the time of subacromial arthroscopy by opening the tendon sheath distal to the attachments of the coracohumeral and superior glenohumeral ligaments. Fraying or disruption of more than 50% is an indication for biceps tenotomy. In some patients with a positive clinical examination for biceps symptoms, pathology involving less than 50% of the tendon width also may be an indication for biceps tenotomy or tenodesis. Instability of the biceps, most commonly seen in conjunction with a subscapularis tear, is a clear indication for biceps tenotomy or tenodesis. If these problems are not addressed at the time of repair, pain is likely to continue even after successful RC healing.

The main complication related to tenotomy is an associated deformity of the biceps muscle, commonly referred to as a Popeye deformity. This is caused by distal retraction of the LHB, resulting in a "balled-up" appearance of the distal biceps muscle. Although this deformity usually does not result in functional problems, many patients prefer that their arm have a relatively normal appearance. This is possible with tenodesis of the LHB tendon. Tenodesis methods have varied from traditional open approaches to newer arthroscopic techniques. The results are the same as long as the tendon heals to the surgical repair site. Disruption of the tenodesis can occur, but revision tenodesis usually is not needed. When an initial tenodesis fails, patients usually are disappointed in the appearance of the deformity but pleasantly surprised by the lack of pain.