

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW: FEBRUARY 26, 2010**

**IRO CASE #:**

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

Left shoulder biceps tenodesis.

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

Diplomat, American Board of Orthopaedic Surgery

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Office visits (11/23/09 – 13/01/10)
- Surgery (12/08/09)
  
- MRI left shoulder (11/19/09)
- Office visits (11/24/09 – 01/13/10)

**TDI**

- Utilization reviews (01/11/10 - 02/01/10)
  
- Office Visits (11/13/09 - 12/16/09)
- MRI left shoulder (11/19/09)
- Surgery (12/08/09)

- Therapy Notes (12/24/09)

ODG have been utilized for the denials.

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

The patient is a male who sustained an injury to his left shoulder on xx/xx/xx, while working. He heard a snap and developed left shoulder pain with inability to move the left shoulder overhead.

Following the injury, the patient was evaluated at Healthcare emergency room (ER) for complaints of left shoulder pain at the intensity of 5/10. History was remarkable for a left shoulder surgery in 1994. Examination revealed pain over the left posterior shoulder. The patient was diagnosed with acute left shoulder pain and was treated with splint, Vicodin and Naprosyn.

M.D., evaluated the patient for complaints of pain and some degree of instability in the left shoulder. Examination revealed a well-healed surgical scar over the anterior aspect of the shoulder, moderate tenderness at the deltoid anteriorly, decreased range of motion (ROM) in all planes with pain during testing, weakness of the supraspinatus to resistance and positive anterior apprehension test. Dr. assessed shoulder pain and ordered a magnetic resonance imaging (MRI) of the left shoulder and placed the patient on work restrictions.

On November 19, 2009, the patient underwent magnetic resonance imaging (MRI) of the left shoulder that revealed severe tendinopathy and superimposed tear of the subscapularis tendon associated with medial subluxation of the tendon of the long head of biceps out of the bicipital groove. There was associated bicipital tenosynovitis. Minimal subacromial/subdeltoid bursal fluid was seen possibly related to rotator cuff tear. Mild tendinopathy of the supraspinatus tendon was also seen with chronic irregularity of the inferior bony glenoid and inferior labrum related to the reported Bankart repair from 1993. Medical history was positive for Bankart repair in 1993.

Dr. reviewed the MRI findings and assessed shoulder joint derangement and referred the patient to an orthopedic surgeon.

M.D., an orthopedic surgeon, evaluated the patient for persistent pain in the shoulder along with swelling and achiness. Examination revealed tenderness of the left shoulder laterally, pain with forward elevation of the shoulder and popping sensation.

On December 8, 2009, Dr. performed arthroscopic subacromial decompression and debridement of labrum of the left shoulder. Postoperatively, he removed sutures and started physical therapy (PT).

On December 24, 2009, the patient attended one session of physical therapy (PT) consisting of therapeutic activities.

On December 30, 2009, the patient complained of popping in the shoulder and subluxation of the biceps tendon. Dr. recommended corticosteroid injection to the shoulder to decrease inflammation; however, the patient declined. Dr. recommended an open biceps tenodesis.

Per utilization review dated January 11, 2010, M.D., denied the request for outpatient open biceps tenodesis with the following rationale. *“The requested outpatient open biceps tenodesis is deemed as not medically necessary as of this time. The patient is post arthroscopy, subacromial decompression, and debridement of labrum of the left shoulder last December 8, 2009, and is presenting with a subluxing biceps tendon. Although there might be a role for surgery in this case, no records of prior conservative treatment done such as immobilization and injections were noted on file to justify an immediate surgery. Additional relevant information from a peer-to-peer contact is needed to substantiate the medical necessity of this request. I spoke with Monica, surgical coordinator. Dr. was not available, however, she was able to speak to me on his behalf. She was unable to provide additional clinical information to warrant the request.”*

On January 13, 2010, Dr. opined that the patient had MRI scan evidence of a biceps tendon subluxation preoperatively, but at the time of surgery, his biceps tendon was not subluxed and was felt to be within its normal position in the bicipital groove. However, postoperatively, as the patient went into PT he started to have symptoms of subluxation of his biceps tendon, which he could feel and an apparent subluxation of his biceps tendon could be palpated. Hence, an open biceps tenodesis of the shoulder was recommended by Dr..

On February 1, 2010, M.D., denied the appeal for outpatient open biceps tenodesis with the following rationale: *“Efforts to contact Dr. have been unsuccessful. As such, this must be answered based on records alone. It appears that surgery was just performed on December 8, 2009, in this case, and the biceps appeared to be in place. It does not appear that any biceps specific conservative care has been rendered. Given that the injury in this case occurred only two-and-a-half months ago with surgery just a month ago, I do not feel that the records alone provide adequate substantiation for the recommendation of an additional procedure.”*

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

I have had the opportunity to review the forwarded records on. Per the records for review, he had injury to the left shoulder. The patient had subsequent MRI completed six days post injury showing medial subluxation of the biceps tendon with severe tendinopathy and superimposed tear of the subscapularis tendon. There was significant associated bicipital tenosynovitis without tendon tear documented by Dr.. There was minimal subacromial subdeltoid bursa fluid. The patient was evaluated as noted by Dr., a member of the Orthopaedic Group. He

proposed arthroscopy of the shoulder with evaluation of the labrum and subscapularis as well as the biceps tendon.

The surgical intervention was performed on December 8, 2009. The patient at that time had arthroscopic subacromial decompression as well as debridement of the labrum in the left shoulder; however, there was no treatment provided for the biceps tendon or the subscapularis tendon.

Postoperatively, the patient was complaining by December 30, 2009, that the shoulder was popping again and that the biceps tendon was subluxing. Dr. proposed repeat surgery with biceps tenodesis. This was presented for utilization review through Worker's Comp Services. The first review was done by Dr.. He determined that the requested surgery was not medically necessary. The rationale provided was that this injury could be treated typically non-operatively.

The follow-up visit with Dr. outlined his rationale that the biceps tendon did not appear subluxed at the time of surgery, but became more symptomatic after going to therapy.

A second review was done by Dr. for Worker's Comp Services. He reports that he was unable to get in contact with Dr. and also denied the proposed surgery.

The patient has clinical subluxation of the biceps. This is documented on the original MRI. I am unable to account for Dr. Sullivan's not addressing that issue more directly intraoperatively. Whether he probed the biceps or not is not stated in the operative note. However, dynamically the patient is having the issue with biceps now. Obviously intraoperatively, the patient is under anesthesia and thus there is no active contraction across the biceps. This may account for the inability to see the medial subluxation.

However given the MRI findings of significant tenosynovitis, medial subluxation of the biceps at that time and the ongoing reported subluxation, currently the necessity for stabilization of the biceps is appropriate and medically necessary. Thus, the denial is overturned. This decision is based on ODG criteria for shoulder surgery as well as the Medical Judgment Clinical Experience And Expertise in Orthopaedic Surgery by this reviewer.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**