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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/8/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a left shoulder arthroscopy with debridement, left shoulder remove/transplant tendon, and left shoulder bicep tenodesis (29826, 23440, 23430).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a left shoulder arthroscopy with debridement, left shoulder remove/transplant tendon, and left shoulder bicep tenodesis (29826, 23440, 23430).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Sports Ortho Surgeon,

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from Services: Pre-auth request – 9/29/10 & 10/13/10, Follow-up Notes – 12/22/09-10/8/10; MD MRI report – 9/21/10; and Denial Letter – 10/4/10 & 10/19/10.

Records reviewed from Sports Ortho Surgeon: , MD MRI report – 4/25/09; MD MRI report – 3/24/09; MD Operative report – 5/27/09, New Patient Report – 4/1/09, Follow-up Notes – 4/17/09-7/27/09; MD Follow-up Note – 8/28/09-12/10/09; and Ortho Care Consultation report – 7/30/10.

Records reviewed from MD Follow-up Note – 8/4/10.

A copy of the ODG was not provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The male was injured on xx/xx/xx . He is status post arthroscopic SLAP repair on 5/27/09. Pain and tenderness over the biceps tendon has been noted. A clinical note from 01/28/10 denoted a biceps tendon injection. A clinical note dated 02/11/2010 reported the patient did not receive any significant pain reduction. An MRI of the left shoulder dated 09/21/2010 reported evidence of a tear of the long-head of the biceps with retraction, and, partial tear of the supraspinatus tendon, a possible so-called “rim-ment” tear. A note dated 09/24/2010 reported the consideration for arthroscopy with debridement and possible biceps tenodesis. Denial letters revealed that surgical intervention is typically not warranted for such proximal biceps origin tears, that the tear is chronic, that no recent exam findings or subjective complaints have been noted and that recent trial and failure of non-operative treatment hasn't been documented.

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

There have been no recent clinical notes evidencing a combination of subjective symptoms and objective findings associated with severity of pain and or functional disability. Therefore, surgical intervention for either the shoulder's partial cuff tear or proximal biceps tendon rupture would not be medically necessary. In addition, applicable ODG guidelines would typically not support such a proposed surgical intervention in the case of a complete and chronic proximal biceps rupture with retraction (especially in light of the preceding), and, the lack of documentation of recent trial and failure of non operative treatment. Therefore, the proposed procedures would not be medically necessary at this time, based on the preceding.

**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.

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.

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

**ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)