

# CASEREVIEW

**8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558**

## Notice of Independent Review Decision

**DATE OF REVIEW:** February 20, 2012

**IRO CASE #:**

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

23430 Left Shoulder Subpectoral Long Head Biceps Tenodesis

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

07/29/08: MRI Cervical w/ 3D interpreted by  
08/20/08: MRI Lumbar w/ 3D  
10/02/07: Electromyography Report on the lower extremities by  
07/10/09: Orthopedic Consult from for the lumbar and cervical spine  
08/31/09: Orthopedic Report from for the lumbar and cervical spine  
09/23/09: Enhanced Interpretive Report by  
10/06/09: Orthopedic Report from for the lumbar and cervical spine  
01/15/10: Orthopedic Report from for the lumbar and cervical spine  
04/22/10: Decision and Order with part of the final decision determining the compensable injury extends to include the tear of the left biceps tendon.  
07/16/10: Post Designated Doctor Required Medical Examination by

08/03/10: Orthopedic Report from LoneStar Orthopedics by regarding the cervical spine  
08/25/10: Operative Report by for the cervical spine  
08/25/10: Surgical Pathology Report by  
08/31/10: Orthopedic Report from for the lumbar and cervical spine  
09/15/10: Adverse Determination Letter regarding a Lumbar Discogram @ L3-4, L4-5  
09/23/10: Adverse Determination Letter regarding a Lumbar Discogram @ L3-4, L4-5  
09/29/10: Report of Medical Evaluation by a designated doctor  
10/06/10: Functional Capacity Evaluation performed at Advocate Pain Management Center  
10/20/10: Notice of Independent Review Decision regarding a Lumbar Discogram  
10/26/10: Orthopedic Report from by  
02/03/11: Decision and Order regarding the Lumbar Discogram  
02/15/11: Orthopedic Report from LoneStar Orthopedics by for the lumbar spine  
03/15/11: Orthopedic Report from LoneStar Orthopedics by for the cervical and lumbar spine  
05/09/11: Orthopedic Report from  
05/17/11: Adverse Determination Letter regarding a Lumbar Laminectomy and Foraminotomy @ L5-S1  
05/27/11: Orthopedic Report from for the lumbar spine  
06/08/11: Adverse Determination Letter regarding a Lumbar Laminectomy and Foraminotomy @ L5-S1  
06/23/11: Notice of Independent Review Decision regarding a Lumbar Laminectomy and Foraminotomy @ L5-S1  
07/14/11: Required Medical Examination by  
07/18/11: Orthopedic Report from for the lumbar spine  
08/08/11: Pre-Authorization Determination Letter for a MRI of Left Shoulder  
08/23/11: MRI Left Shoulder interpreted by  
08/30/11: Orthopedic Report from  
09/30/11: Decision and Order regarding the Lumbar Laminectomy and Foraminotomy @ L5-S1  
10/18/11: Orthopedic Report from LoneStar Orthopedics by for the lumbar spine  
10/19/11: Self-Insured/Carrier's Request for Review regarding Lumbar Laminectomy and Foraminotomy @ L5-S1  
10/27/11: Claimant's Response to Carrier's Request for Review  
11/16/11: Operative Report by regarding lumbar spine  
11/21/11: Orthopedic Report from for lumbar spine  
01/04/12: Orthopedic Report from  
01/12/12: UR performed by  
01/19/12: Orthopedic Report from LoneStar Orthopedics by  
01/31/12: UR performed by

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a male who was riding a motor cycle on xx/xx/xx when he was struck by another vehicle. He sustained injuries to his cervical spine, lumbar spine, and left shoulder.

On June 3, 2010, the claimant was evaluated by who reported he had complaints including cervical pain with sharp pain shooting down into his left hand, with numbness in the left fingers. He also complained of weakness in his left hand which resulted in wrist volar flexion. On physical examination he had positive Spurling sign with shooting pains out into his left hand. He had numbness along the 4<sup>th</sup> and 5<sup>th</sup> digits of his left hand. He had weakness in the wrist extensors. He had some hyperreflexia in the left triceps but absent biceps and brachioradialis reflexes. The biceps reflexes were the same on the right, but the brachioradialis reflex is significantly diminished when compared to the right. Impression: 1. Aggravation of hip osteoarthritis. 2. Lumbar radiculopathy. 3. Aggravation of cervical spondylosis. 4. Biceps tear.

On October 26, 2010, the claimant had a follow-up evaluation with who reported he had a cervical discectomy and fusion performed on August 25, 2010 and his neck pain was now 1/10. However, he had still not regained strength in his left arm. On physical examination of the left upper extremity, sensation was intact, but he had some residual weakness with the intrinsic in his left hand. recommended additional rehabilitation.

On May 9, 2011, the claimant had a follow-up evaluation with who on physical examination found his circumference to be 38.5 cm on the right upper arm and 34 cm on the left upper arm. His forearm circumferences were 33 cm on the right and 30 cm on the left. He also had a visible left longhead of the biceps defect. stated that even though the claimant state the left shoulder was a compensable injury, the adjustor had never mention it to him, so they would investigate it.

On August 23, 2011, MRI of the left shoulder, Impression: 1. Although suboptimally profiled, there is a probable full thickness tear of the long biceps. Consider correlation with MR arthrogram for further assessment. 2. There is a tiny intrasubstance partial tear of the distal supraspinatus tendon superimposed on supraspinatus tendinosis. There is also infraspinatus tendinosis. There is also irregularity along the articular and bursal surfaces of the distal supscapular tendon compatible with partial tears. 3. Fraying of the superior labrum is compatible with type I SLAP tear. 4. Os acromiale. 5. Acromioclavicular osteoarthritis mildly encroaches on the supraspinatus outlet. 6. A 9x5 mm T2 hyperintense cystic focus with internal septation seen anterior to the scapularis muscle and may represent a small amount of fluid in the subcoracoid bursa versus a tiny ganglion or synovial cyst. 7. Moderate fatty atrophy of the supraspinatus muscle belly is noted.

On August 30, 2011, the claimant had a follow-up evaluation with who noted on physical exam that his left shoulder revealed positive impingement sign and pain with abduction. He had 4/5 motor strength mostly limited by pain. He has a bicep tendon defect that is palpable and visible. Impression: Bicep tendon rupture, left shoulder, and rotator cuff tendonitis, left shoulder. performed an injection of the left shoulder subacromal space.

On January 4, 2012, the claimant had a follow-up evaluation with who noted he had complaints of weakness and cramping from the anterior portion of his arm. He also

noted that when he raises his arm overhead and tries to pull down, that his back lacks strength. On physical examination the claimant demonstrated the pulling down activity and there was asymmetry on his back. The latissimus dorsi on the left side retracts up toward the shoulder whereas it does not on the right side. This seemed to be consistent with a distal latissimus dorsi rupture. The claimant was able to reproduce this with shoulder depression. Examination of the left proximal arm shows the typical Popeye deformity of the arm. recommended a left subpectoral bicep tenodesis.

On January 12, 2012, performed a UR on the claimant. Rational for Denial: According to Official Disability Guidelines consideration for tenodesis for the long head of the biceps requires that the claimant should be a young adult. It is not recommended as an independent stand alone procedure. Surgery is not indicated if three or more months have elapsed. And those that are indicated should be repaired within two to three weeks.

On January 19, 2012, the claimant had a follow-up evaluation with who reported in response to the denial: The patient does have objective clinical findings as well as imaging clinical findings that reveal a longheaded bicep tendon rupture. The patient has exhausted an abundant course of physical therapy as well as oral anti-inflammatories and a corticosteroid injection with temporary relief. Physical examination of the patient's left proximal arm shows the typical Popeye deformity of the arm. He continues to have limitation in his motor strength. He continues to experience complaints of weakness and cramping from the anterior portion of his arm. He notes his pain level raises when he puts his arm overhead and tries to pull down.

On January 31, 2012, performed a UR on the claimant. Rational for Denial: The claimant sustained an injury to the left shoulder in 2008. The claimant is noted to be a 57 year old male with degenerative changes in the cervical spine, lumbar spine and hips as well. The claimant is noted to have full thickness rupture of the biceps tendon. Guideline would not support a biceps tenodesis for an injury greater than two to three weeks out. This is a surgical procedure only supported in the younger adult population by guidelines. It is noted this procedure is almost never considered in full thickness ruptures. Biceps tenodesis is not recommended as an independent, stand alone procedure. The previous non-certification was based on the age of the claimant and was not felt to have an acute injury. The previous non-certification is supported.

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

The previous adverse determinations are upheld. The request for Left Shoulder Subpectoral Long Head Biceps Tenodesis does not meet ODG criteria. The ODG states the procedure should be performed on a "young adult". The claimant is 57 years old. The ODG also indicates that the procedure should take place "within 2-3 weeks of injury or diagnosis". It has been over 3 years since the injury occurred. The claimant has a diagnosis of a full longheaded bicep tendon rupture. ODG also states that surgery is almost never considered in full thickness ruptures. Therefore, the claimant

would not receive the benefits of the Left Shoulder Subpectoral Long Head Biceps Tenodesis and based on ODG criteria it is not medically warranted.

ODG:

<p>Surgery for ruptured biceps tendon (at the shoulder)</p>	<p>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. (<a href="#">Mazzocca, 2008</a>) (<a href="#">Chillemi, 2007</a>) 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. (<a href="#">Rantanen, 1999</a>) When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. In tenodesis, the surgeon cuts the normal attachment of the biceps tendon on the shoulder socket and reattaches it to the humerus. This maneuver takes pressure off the cartilage rim of the shoulder socket (the labrum), and a portion of the tendon can be resected. The alternative, a tenotomy, simply involves cutting and suturing the tendon. With tenodesis, patients have a longer recovery, but they're also more likely to have better function and a normal appearing biceps muscle. With tenotomy, there can be arm cramping, weakness, and a biceps tendon abnormality called a "Popeye deformity". Tenodesis is a better approach except for the aged, senile, and less active. (<a href="#">Koh, 2010</a>)</p> <p><b>ODG Indications for Surgery™ -- Ruptured biceps tendon surgery:</b></p> <p><b>Criteria</b> 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 <u>incomplete tear or fraying of the proximal biceps tendon</u> (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):</p> <p><b>1. Subjective Clinical Findings:</b> 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</p> <p><b>2. Objective Clinical Findings:</b> Partial thickness tears do not have classical appearance of ruptured muscle. PLUS</p> <p><b>3. Imaging Clinical Findings:</b> 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.</p> <p><b>Criteria</b> for tenodesis of long head of biceps with diagnosis of <u>complete tear</u> of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required:</p> <p><b>1. Subjective Clinical Findings:</b> Pain, weakness, and deformity. PLUS</p> <p><b>2. Objective Clinical Findings:</b> Classical appearance of ruptured muscle.</p> <p><b>Criteria</b> 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. (<a href="#">Washington, 2002</a>)</p>
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**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)**