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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**05/13/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Repair right long head of biceps tendon w/ tendon graft.

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

Board Certified Orthopedic Surgeon

**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 medical necessity exists for each of the health care services in dispute.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:** This patient is a male with a reported date of injury of xx/xx/xx. He presented to the emergency room on that date, xx/xx/xx, indicating that he complained of a right shoulder and upper arm injury while working. He stated that he tried to carry at work and heard a pop in his right shoulder and lost strength to his right arm. He also complained of a knot to his right biceps. Exam revealed tenderness and pain with abduction to the right shoulder, and a muscular knot deformity was seen to the right biceps. Pain was noted with flexion of the elbow. He had good sensation in radial pulses. X-rays of the right shoulder failed to reveal fractures or dislocations and were read. He was given pain medication and discharged at that time. He returned on 03/04/2013

with an evaluation. The exam revealed a deformity and a proximal biceps tendon contraction with tenderness noted. The biceps tendon was shortened, and there was a palpable mass noted in the mid to upper arm. On 03/12/2013, an MRI of the right shoulder was obtained, demonstrating a tear of the long head of the biceps tendon with retraction below the field of view. He had a type II acromion, and a SLAP tear was seen extending into the posterior superior labrum. There was moderate osteoarthritis about the acromioclavicular joint. The exam was read. He returned to clinic on 03/14/2013 with an evaluation. He felt that his symptoms were not improving. He had tenderness to the anterior aspect of his shoulder and about the lateral aspect of his shoulder. The biceps muscle was shortened, and there was a palpable mass in the mid to upper arm. The MRI was reviewed. On 03/19/2013, he returned for further evaluation, and the exam essentially remained unchanged. On 03/25/2013, he was seen in physical therapy. Manual muscle testing was 4+/5 to the right shoulder with external rotation, internal rotation and abduction. He had a Popeye deformity to the right elbow, which demonstrated 4/5 decreased strength in flexion. He returned to physical therapy on 04/01/2013 with an evaluation. On 04/02/2013, this patient was seen in clinic. He was noted to have a right torn biceps tendon and was undergoing physical therapy at that time. He requested a second opinion and complained of constant right arm aching pain and a lack of strength in his arm. He had decreased range of motion in the right shoulder as compared to the left, and the MRI was reviewed. The plan was to recommend more therapy; and if he did not improve, an AC joint resection with a labral repair was recommended. Consideration for repair of the long head of the biceps with tendon graft, possibly including the palmaris longus tendon, was recommended. On 04/04/2013, this patient was seen back in physical therapy. On 04/10/2013, a letter was submitted indicating that the patient had a ruptured long head of the biceps tendon. Surgery was recommended. He requested another review for this request.

## IRO REVIEWER REPORT TEMPLATE -WC

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

On 04/08/2013, a non-authorization recommendation was submitted. This indicated that ruptures of the proximal or long head of the biceps tendon are usually due to degenerative changes in the tendon and can usually be managed conservatively since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young bodybuilders, but it is not necessary for function. It was noted that nationally accepted clinical practice guidelines, including the ODG, were used which did not recommend surgery for a rupture of the biceps tendon in the shoulder, and approval was not recommended. Citations included the Official Disability Guidelines (Shoulder Chapter). On 04/19/2013, a reconsideration decision was submitted. This indicates that the patient did have a biceps tear on 03/02/2013, and a repair would be indicated in a young manual laborer. The injury was approximately 6 weeks prior to the reconsideration, and there was no indication for a graft procedure for the biceps tear. The patient had reduced motion and weakness, and an MRI revealed a SLAP tear in the biceps rupture. It was noted that repair could still be possible without the need for a graft. It was noted that there were no peer review studies that showed that the graft procedure was needed at that time. Additionally, it was noted that the provider stated that the surgery may not work. Therefore, the request was non-certified. The additional records provided for this review indicate that this patient does have a rupture of the long head of the biceps tendon with a Popeye defect in his right upper extremity. He has decreased strength and range of motion; this may be secondary to the defect, but it also may be secondary to his previously described labral tear and impingement syndrome to his right shoulder. Guidelines cited for both the initial determination and the reconsideration included the Official Disability Guidelines (Shoulder Chapter). This reviewer is also citing that nationally-recognized guideline. The ODG indicates that surgery for a ruptured biceps tendon at the shoulder is not recommended as an independent standalone procedure, and there must be evidence of an incomplete tear. It was noted that partial thickness tears do not have the classical appearance of rupture muscles, and imaging should rule out a full thickness rotator cuff tear. If there is a complete tear of the proximal biceps tendon, surgery almost never is considered in full thickness ruptures. If there is a full thickness rupture, there should be documentation of pain, weakness and deformity and a classical appearance of a ruptured muscle. As guidelines used in the initial determination and the appeal determination indicate that this repair is not considered medically necessary, the additional records provided do not provide substantial information to go outside of guideline criteria. Additionally, as the date of injury was approximately xx/xx/xx, the opportunity for a repair at this time would be minimal. Therefore, the initial determination and appeal determination are upheld.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**