Core 400 LLC

An Independent Review Organization
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Description of the service or services in dispute:
Shoulder arthroscopy, extensive debridement, rotator cuff repair, distal clavicle excision, subacromial decompression and biceps tenodesis

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgery

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

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

Patient Clinical History (Summary)
The patient is a XXXX, who was diagnosed with bicipital tendinitis in the right shoulder and complete rotator-cuff tear/rupture of the right shoulder.

The patient was working XXXX using XXXX upper extremities, mostly XXXX right side since XXXX was right-handed. On XXXX, during that activity, XXXX started feeling pain and discomfort in XXXX right shoulder, but due to the nature of the job XXXX had to continue without stopping.

On XXXX, a progress report by XXXX, documented that the patient reported increased pain with overhead activity and reaching behind XXXX back. The pain was rated as 6/10. The patient was treated with physical therapy. The physical examination of the right shoulder revealed forward flexion 130 degrees, limited due to pain. There was positive Neer test, Hawkin's test with positive O'Brien's test. Scaption strength was 4/5. There was positive acromioclavicular joint compression test with positive Speed's test and Yergason's test. The assessment included bicep tendinitis of right upper extremity, a complete tear of right rotator cuff and injury of the right acromioclavicular joint. Per note, the patient had failed conservative measures. A shoulder arthroscopy was recommended.

The treatment to date included medications, physical therapy, rest and activity modifications.

X-ray of the right shoulder dated XXXX revealed normal findings.

Per a right shoulder MRI report dated XXXX, a distal supraspinatus tendon tear with 2 cm of retraction from the anterior facet greater tuberosity foot plate was noted with infraspinatus tendon undersurface and intrasubstance grade partial-thickness tearing. It also revealed myotendinous strain, joint effusion and subdeltoid/subacromial bursal fluid extrusion and subacromial arch stenosis, but no labral tear.

The previous utilization review on XXXX indicated that peer to peer contact could not be completed. The reviewer indicated that the biceps tenodesis was not necessary due to the absence of biceps tendon zcontact, noncertification was advised. The letter of appeal from the provider indicates the biceps tenodesis is a possibility. A 2nd review was and completed on XXXX. The reviewer again indicated that the biceps tenodesis was not necessary given the absence of labral pathology or biceps tendon pathology on imaging.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The prior reviewers were correct indicating that the biceps tenodesis would not be supported based on medical documentation submitted. The included radiology reports do not indicate evidence of labral pathology or biceps tendon pathology that would support the biceps tenodesis. The treating provider indicates that biceps tenodesis may be a possibility, but without evidence of pathology, preauthorization for this portion of the procedure would not be indicated. Retrospective certification may be necessary if pathology is identified during direct visualization on arthroscopy. The partial certification proposed by the previous reviewers to include shoulder arthroscopy with extensive debridement, rotator cuff repair, distal clavicle resection, and subacromial decompression would be indicated. Preauthorization for the biceps tenodesis would not be supported at this time. As such, partial certification proposed by the 2 prior reviewers would be recommended.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐☑ ODG-Official Disability Guidelines and Treatment Guidelines
  Shoulder Chapter
  Surgery for biceps tenodesis (or tenotomy)

Recommended for advanced biceps tendinopathy or rupture under age 55, as well as for a type II or type IV SLAP lesions in patients over 35 years of age.

See also SLAP lesion diagnosis; Surgery for SLAP lesions; Surgery for ruptured proximal biceps tendon (shoulder); and Surgery for rotator cuff repair for related indications and discussion.

Criteria for Surgery for Biceps tenodesis (or tenotomy):

- History, physical examination, and imaging indicate significant shoulder biceps tendon pathology or rupture
- After 3 months of failed conservative treatment (NSAIDs, injection, and PT) unless combined with acute rotator cuff repair
- An alternative to direct repair for type II SLAP lesions (fraying, some detachment) and type IV (> 50% of biceps tendon involved, vertical or bucket-handle tear of the superior labrum, extending into biceps)
- Generally, type I and type III SLAP lesions do not need any treatment
- Age > 35 with Type II and IV SLAP tears (younger optional if overhead throwing athlete)

- Age < 55 for non-SLAP biceps pathology, especially with concomitant rotator cuff repair; tenotomy is more suitable for older patients (past age 55)

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)