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Date notice sent to all parties: 06/26/18

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left shoulder arthroscopic rotator cuff repair and biceps longus tendon tenodesis

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons
Diplomate of the American Board of Orthopedic Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> of the health care services in dispute.

Left shoulder arthroscopic rotator cuff repair and biceps longus tendon tenodesis – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

XX examined the patient on XX and noted XX had a left biceps Popeye deformity. The assessment was a left biceps tear. A left shoulder MRI dated XX showed a tear of the intrarticular long head of the biceps tendon with distal retraction of the torn tendon fragments that were now positioned within the superior bicipital groove. There was tendinosis and tiny partial thickness intrasubstance delamination tear along the subscapularis myotendinous junction. There was mild supraspinatus and infraspinatus tendinosis without a tear. Moderate AC joint arthritis was also noted. The humeral MRI noted a tear/rupture of the intrarticular

long head of the biceps tendon with distal retraction of the torn tendon fragments with associate soft tissue edema surrounding the proximal long head of the biceps myotendinous junction. XX examined the patient on XX. The left biceps was noted to be balled up distally with normal ROM. There was pain with impingement testing of the left shoulder. There was slight weakness with lift off testing. The MRIs were reviewed and biceps tenodesis and arthroscopy were recommended. On XX, the patient noted XX symptoms had worsened and XX carrier had asked for a follow-up before considering surgery. It was felt XX had a tear of the long head of the biceps tendon with possible partial subscapularis tear. Biceps tenodesis with possible arthroscopic rotator cuff repair was recommended and a preauthorization request was submitted on XX. On XX XX, M.D., on behalf of XX, provided a non-authorization for the requested surgical procedure. In an occupational therapy note on XX, it was felt there was not a conservative option for the patient given the complex nature of XX tear. It was felt supervised therapy was not indicated. On XX another preauthorization request was submitted, which XX, M.D., also on behalf of XX, provided a non-authorization for on XX. XX followed-up with the patient on XX. It was noted the carrier had denied XX surgery, as XX needed an injection first. XX noted XX had cramping in XX biceps and was unable to wash XX hair without cramping. XX left biceps was again noted to be balled up distally. External rotation was 70 degrees and scaption was 160 degrees. It was noted the therapist declined to do any treatments and it was noted they could not rule out a low grade partial thickness tear or subacromial impingement. XX performed a left shoulder subacromial space injection was done, but XX advised the patient it would not improve XX biceps cramping. Open biceps tenodesis with possible arthroscopic rotator cuff repair, debridement, and acromioplasty if indicated were recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient is a XX who was XX, and felt a pop in XX left biceps. Subsequent physical exam and MRI imaging was consistent with a rupture of the long head of the biceps. The MRI scan did not show any evidence of full thickness rotator cuff tearing, but, at most, minimal tendinosis and moderate degenerative changes of the acromioclavicular joint. The patient was then seen by XX who recommended left shoulder arthroscopy with biceps tenodesis on evaluation of XX. The requested procedure was non-certified on initial review on 0XX. The non-certification was upheld on reconsideration/appeal by XX, M.D., orthopedic surgeon, on XXXX, who did perform a peer-to-peer. Both non-certification opinions were based upon the fact that the request did not meet the criteria as outlined by the Official Disability Guidelines (ODG). The ODG recommends surgery for biceps tenodesis or tenotomy for advanced biceps tendinopathy or rupture under the XX, as well as for a type 2 or type 4 superior labrum anterior and posterior lesion in patients XX of age. The ODG criteria for surgery for biceps tenodesis (or tenotomy) include the following: 1) History, physical examination and imaging indicating significant shoulder biceps tendon pathology or rupture. 2) After three months of failed conservative treatment (non-steroidals, injection, and physical therapy), unless combined with acute rotator cuff repair. 3) An alternative

to direct repair for type 2 SLAP lesions (fraying, some detachment) and type 4 (greater than 50% of biceps tendon involved, vertical or bucket-handle tear of the superior labrum extending into the biceps). 4) Generally type 1 and type 3 SLAP lesions do not need any treatment. 5) Age XX with type 2 and type 4 SLAP lesions (younger optional if overhead throwing athlete). 6) Age less than or equal XX for non SLAP biceps pathology, especially with concomitant rotator cuff repair. Tenotomy is more suitable for older patients (XX). Risk versus benefit compared with primary SLAP repair: Risks are lower with tenotomy or tenodesis. Complications of tenotomy are mild and include cosmetic deformity, residual pain or achiness, and slight strength deficit for elbow flexion and forearm supination. Patient satisfaction over 90% can still be expected following tenotomy with mild and/or infrequent reports of cosmetic deformity (13%), occasional cramping (19%), and subjective weakness (17%), mostly in men. Satisfaction is remarkably high for tenotomy, especially for XX in XX or older individuals. Tenodesis complications can include failure of fixation resulting in cosmetic deformity and/or residual pain, stiffness, infection, hematoma, neurological or vascular injury, fracture, and complex regional pain syndrome. Tenodesis in XX, XX resulted in only 5% complications and less than 1% failures requiring revision.

Based on the documentation provided for review, the patient had only a one-time evaluation by an occupational therapist, who noted on her evaluation that XX pain level was 0. More recently, on XX, XX underwent a steroid injection to XX subacromial space and XX response to the injection is not known at this time. XX, on XX, also reported the patient was doing well. The request does not meet the criteria as outlined above by the evidence based ODG. In addition, there is no evidence of full thickness rotator cuff repair and rotator cuff repair is not medically indicated, based upon the medical documentation reviewed. Therefore, the requested left shoulder arthroscopic rotator cuff repair with biceps longus tendon tenodesis is not medically necessary, reasonably related, or supported by the evidence-based ODG and the previous adverse determinations should be upheld at this time.

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
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- X 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)