



supraspinatus tendon extending to involve the rotator interval was noted at that time. On 11/16/2011, this patient was seen back in clinic. She was noted to have a re-tear of a rotator cuff and conservative measures in the form of injection was not considered at that time as it was indicated this would not make the cuff heal. Therefore, an injection was performed with a steroid at that time. On 11/30/2011, the patient was back in clinic stating the injections did not help. A repeat MRI was performed on 11/30/2011, demonstrating findings suggestive of a low grade partial thickness articular surface tear of the posterior fibers of the supraspinatus tendon with associated tendinosis. Subacromial/subdeltoid bursitis was also indicated on this exam. On 12/06/2011, this patient returned to clinic. She continued to have pain about the shoulder. Surgery was recommended. On 01/24/2012, this patient was seen back in clinic. She continued to complain of right shoulder pain. Examination of the right shoulder revealed tenderness to palpation in the anterolateral aspect. Range of motion was 90 degrees in abduction, 90 degrees in flexion, 20 degrees in internal rotation and 20 degrees in external rotation. X-rays of the shoulder performed on that date showed a high-riding humeral head which causes impingement. On 02/14/2012, this patient returned to clinic for follow-up. She had moderate and constant pain to the right shoulder. She had 100 degrees of abduction, 100 degrees of flexion, and 20 degrees of internal and external rotation.

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

On 12/28/2011, an adverse determination for the requested surgery was submitted. There was no comprehensive physical examination of the shoulder provided for that review that demonstrated weakness with rotator cuff testing or impingement. In addition, a thorough discussion of the treatment history and sequence of events was not provided, both surgical and nonsurgical treatments given the significant prior surgical history in the right shoulder. Furthermore, allografts and xenografts for rotator cuff tears were reported to be under study. Therefore, an adverse determination was rendered. The subsequent appeal review was performed on 02/17/2012. After speaking to the provider, the reviewer discussed the ODG with the provider. In the absence of an MRI confirmation of a full thickness tear with retraction in the rotator cuff, pre-authorization could not be justified as Guidelines indicate that 80 % of partial tears would get better without surgery and recommended 3-6 months of conservative care before undergoing surgery. Based on the documentation of the Guidelines, the adverse determination was recommended. The MRI performed on 11/30/2011 was submitted for this review, and there is no full thickness tear, but there may be a low-grade partial thickness articular surface tear with mild tendinosis. The rest of the visualized rotator cuff is thought to be intact based on this MRI report. Therefore, the appeal is upheld as there is lack of documentation of a full thickness tear which would preclude the need for conservative care before going to surgery.

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

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

**REFERENCES: Official Disability Guidelines, Shoulder Chapter, Online Version**

**ODG Indications for Surgery -- Rotator cuff repair:**

**Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:**

**1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS**

**2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS**

**3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.**

**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.**

**(Washington, 2002)**

**For average hospital LOS if criteria are met, see Hospital length of stay (LOS).**