

<b>Case Number:</b>	CM15-0131131		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	06/09/2014
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57-year-old male who sustained an industrial injury on 6/9/14. Injury occurred while he was working as a lighting technician, and was electrocuted with left hand entrance and exit left leg exit. He was admitted to the ICU for 3 days. The 12/29/14 right shoulder MRI impression documented a focal full-thickness retracted tear of the supraspinatus anteriorly, moderate acromioclavicular joint arthropathy with lateral subacromial spurring, and moderate joint effusion into the subacromial-subdeltoid bursa. The 12/29/14 left shoulder MRI revealed a full thickness tear of the supraspinatus anteriorly, moderate joint arthropathy, and moderate joint effusion into the subacromial-subdeltoid bursa. The 6/5/15 initial orthopedic report cited constant grade 5-6/10 right and grade 5/10 left shoulder pain, increased with prolonged overhead arm use. Shoulder exam documented loss of range of motion and tenderness over the acromion, levator scapula, impingement area, and biceps tendon. There was rotator cuff weakness with positive impingement signs. The diagnosis was bilateral rotator cuff tear. Authorization was requested for right shoulder arthroscopy, subacromial decompression, mini-Mumford, and rotator cuff repair and associated surgical requests, including assistant surgeon. The 6/23/15 utilization review certified a request for right shoulder arthroscopy with rotator cuff repair, subacromial decompression, and mini Mumford. The request for an assistant surgeon was non-certified, as guidelines would not support the use of an assistant surgeon in the setting of a shoulder arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Assistant Surgeon:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines 19th edition: assistant surgeon guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT codes 29826, 29287 and 29824, there is a "2" in the assistant surgeon column for each code. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.