ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 02/24/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of approval for exploration of the left groin.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., surgeon specializing in General Surgery, member and fellow of the American College of Surgeons, and a fellow of the American Board of Quality Assurance and Utilization Review Physicians.

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

_____Upheld (Agree)

__X __Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

There is evidence in the literature that groin exploration in the case of pain after hernia repair is a medically necessary service.

ODG Guidelines were not utilized in this particular case as they were found to be not contributory and the reviewer found credible evidence through cited research which would indicate medical necessity for this procedure.

INFORMATION PROVIDED FOR REVIEW:
1. Previous Adverse Determinations and the first review
2. Medical records covering the dates of 01/06/07 and 01/07/07 as well as a history and physical from that date
3. Subsequent medical records dated 12/07/07 through 02/05/08

ODG Guidelines were not presented for review.

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INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The patient is a white male who originally injured himself while lifting approximately 150 pounds. He then had noticed a bulge in his left groin. He was found to have a tender, acute left inguinal hernia. He underwent a repair with Marlex mesh with the Marlex being placed below the transversalis fascia and not secured in place. However, the fascia was secured over it, and it was reinforced using a figure-of-8 suture. Postoperatively he appears to be well as there are no records until 12/07/07, which is 11 months later, where there is a handwritten note indicating that the physician, Dr. had spoken with Dr. and that a neuroma was suspected, and a nerve block should be attempted. Dr. did a nerve block, which indicated that there was greater than 90% reduction in the pain. He infiltrated the tender area over the left groin, and he instructed the patient to follow up with him in 10 days.

The next note is dated 12/14/07. The patient continued to have pain. This was again handwritten, so it is hard to read. The note indicates that the major part of the pain was in the deep area. He could localize the pain between the testicle and the external ring. He apparently again infiltrated into the area again with 90% relief of pain without infiltrating the inguinal canal. Apparently the area of tenderness was above the muscles in the subcutaneous tissue, perhaps even within the subcutaneous tissue. The surgeon's recommendation at that time was to explore the area to evaluate the anterior fascia.

There is another note dated 01/10/08. The patient returned with increased pain and was out of medications. He had been in constant pain for two days. The note goes on to complain about communication problems. Physical examination still had a very tender left groin and the pain was in the subcutaneous tissues. The recommendation is that the patient should have the scar excised. He was angry with the insurance company and was given Ultracet for pain.

The next note is dated 02/05/08. It states the patient still had pain in the left groin. The doctor reiterates that he many times tried to attempt to review this with the general surgeon, but he had gotten no response. The exam was still tender. It still seemed to be superficial to the inguinal canal. The note states he would probably due the procedure under local anesthesia in his office.

It appears that this injured employee had an uncomplicated inguinal hernia repair and then approximately eleven months later developed some pain in his scar in the left groin that appears to be superficial and not actually within the repair itself. It appears he has had two nerve blocks that relieved the pain by injecting into that particular area.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
Basically, patients often have pain after hernia repair. There have been a number of studies, most of which are from databases in Europe where they have nationalized healthcare. In particular, there is one by Bay-Nielsen, "Pain and Functional Impairment One Year After Herniorrhaphy, a Nationwide Questionnaire Study," published in the Annals of Surgery, January 2001, Volume 33. The conclusion is that one year after

inguinal hernia repair, pain is quite common 28% and associated with functional impairment in more than half of those with the pain. The intensity of pain while at rest was moderate and severe in 3%, and physical activity pain moderate to severe in 8%, impairment of specific daily activities as the result of pain was reported in 16%. The pain characteristics were predominantly sensory-type pain. There was also an article from the British Journal of Surgery published in 1999, Volume 86, page 1528-1531 by Kellison, "Respective Study of Chronic Pain after Groin and Hernia Repair." Their conclusions after studying 419 questionnaires from patients who were studied one year after surgery was that 19% reported some pain, 6% had moderate or severe pain, pain restricted daily function in 6% of the patients as well, and chronic pain appears to be a significant pain after open groin hernia repair. It may even be worse after surgery for a recurrent repair, maybe predicted by the intensity of early postoperative pain. This gentleman developing pain after his inguinal hernia repair is not uncommon, ranging in the 6% to 10% range of having severe pain that can become chronic. The causes of this pain are not clear, but there are no good studies delineating whether or not laparoscopic hernia repair or other types of closed or minimally invasive repairs make a difference. There is some debate in the literature over the best way to diagnose this, and there appears to be no specific way to diagnose the problem. There is a study in the Journal of the American College of Surgeons from November 1998, Volume 187, pages 514-518, by Heiss and Starling, "Mesh Inguinodynia: New Clinical Syndrome After Inguinal Herniorrhaphy?" Their study proposes as to whether neuralgia after conventional inguinal hernia is rare or not. They have reviewed the treatment ranges from local injection to remedial surgery, and they are variable in the results. They note that the increasing popularity of prosthetic mesh repairs has not eliminated these pain syndromes from occurring. Recommended management in these situations is extremely difficult. They reviewed twenty patients who were evaluated and found that symptoms persisted for almost a year before remedial surgery. The patients underwent inguinal re-exploration and mesh removal and/or iliohypogastric neurectomy. Twelve out of twenty patients, 60%, in followup had good results. Their conclusion was that remedial inguinal exploration and mesh removal with or without neurectomy resulted in favorable outcomes in 60% of the patients with mesh herniorrhaphy and chronic pain. It appears that coincident neurectomy affords better results than mesh removal alone. Relief with nerve block did not predict favorable outcomes.

Given this information in the literature, I would say that this gentleman has developed pain in his inguinal hernia incision after a mesh inguinal hernia repair. He has responded to nerve blocks. However, his pain is recurrent and continuing. The best treatment at this time is repeat exploration of the groin and neurectomy and excision of possible neuroma. This gives relief in 60% of these patients. The response to nerve block does not predict the possibility of success. However, it does anecdotally give evidence that it may succeed.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____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.
_____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.
__X __Peer reviewed national accepted medical literature as described above.
__X __Other evidence-based, scientifically valid, outcome-focused guidelines as described above.

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