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Amended May 9, 2011

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: May 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Exploration of the right lower quadrant/right groin with removal of foreign body under ultrasound guidance.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in General Surgery.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overtured (Disagree)
 Partially Overtured (Agree in part/Disagree in part)

The requested service, exploration of the right lower quadrant/right groin with removal of foreign body under ultrasound guidance, is medically necessary for the patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 4/11/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/13/11.

3. Notice of Assignment of Independent Review Organization dated 4/21/11.
4. Surgical Consultation Notes from MD, FACS dated 2/17/11, 2/16/11, 12/29/10, 12/18/10, 9/17/10, 6/29/10, 5/12/10, 4/27/10, 4/2/10, 3/23/10, 1/13/10, 11/18/09, 8/14/09, 8/4/09, and 7/7/09.
5. Request for Exploratory Surgery with Removal of Foreign Body from MD dated 3/2/11.
6. Patient Referral Request Form from MD dated 2/17/11.
7. Precision Pathology Office Visit dated 3/25/10.
8. Surgery Center Operative Report dated 3/25/10.
9. Health Care Radiology Report dated 6/6/09.
10. Radiology Imaging Center Final Report dated 11/16/10.
11. Evaluation Center DDE/RME Report dated 8/11/10.
12. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work injury on xx/xx/xx when he slipped while working an. The patient experienced pain from his testicle to the right side of his lower abdomen. By report, an ultrasound performed on 1/21/09 showed probable hemangioma of the liver and findings suggestive of a muscle tear of the rectus abdominal on the right. An ultrasound of the scrotum and contents performed on 6/6/09 showed probable right omental inguinal hernia and a 6 mm cyst in the head of the right epididymis. A CT scan of the abdomen and pelvis without contrast showed that the gallbladder was not visualized, probably surgically absent; no acute abnormalities were present; and no hernias were identified. On 3/25/10, the patient underwent laparoscopic right inguinal hernia repair with laparoscopic ultrapro mesh insertion with ablation of right ilioinguinal nerve. An ultrasound of the right lower quadrant performed on 11/16/10 showed postoperative suture artifact in the right rectus abdominus muscle. The patient's surgeon noted the ultrasound revealed the presence of a hyperechoic lesion. The patient continues to experience pain and has undergone conservative modalities including nerve block and medications without lasting benefit. The surgeon has requested authorization for exploration of the right lower quadrant/right groin with removal of possible foreign body under ultrasound guidance.

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

The patient is status post laparoscopic right inguinal hernia repair and ilioinguinal nerve excision. He has had a nerve block as well as a trial of medication to treat his pain but continues to be symptomatic. The findings documented in the records provided are suggestive of recurrent hernia due to shrinkage of mesh or a neuroma secondary to a suture granuloma from the tacker. The patient requires an open exploration of the groin for foreign body removal and/or hernia repair, depending on the findings. Given his presentation, the patient's condition is not likely to respond to non-surgical modalities; as such, the requested service is medically reasonable and necessary. This determination is based on medical judgment, clinical experience and expertise in accordance with accepted medical standards. There are no applicable national guidelines for the

requested service. The Official Disability Guidelines (ODG) were reviewed; however, they do not address this specific situation.

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
- 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
(WERE REVIEWED; THEY DO NOT ADDRESS THIS SITUATION)
- 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)