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Notice of Independent Review Decision

DATE OF REVIEW: 12/20/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient right inguinal nerve resection

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

Board Certified in Internal Medicine

REVIEW OUTCOME

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

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Outpatient right inguinal nerve resection - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

CT scan of the abdomen dated 03/31/11 and interpreted by M.D.
Another CT scan of the abdomen dated 04/11/11 and interpreted by M.D.
Emergency room report dated 04/26/11 with M.D.
Laboratory studies dated 04/26/11 and 05/12/11
Another CT scan of the abdomen dated 04/26/11 and interpreted by M.D.
An emergency room record dated 05/12/11 from Dr.
A testicular ultrasound dated 05/12/11 and interpreted by M.D.
Admission report dated 05/20/11 from M.D.
Evaluation with M.D. dated 05/22/11
Laboratory studies dated 05/22/11 and 09/07/11
Evaluation with M.D. on 05/24/11
Procedure report from Dr. dated 05/25/11
A surgical consultation dated 05/27/11 with M.D.
Discharge summary dated 05/28/11 from M.D.
Evaluations with D.O. dated 06/07/11, 06/21/11, and 06/28/11
Emergency room record dated 06/30/11
Clinical report from Medical Center of dated 06/30/11 M.D.
An emergency room report dated 09/07/11
A CT scan of the abdomen and pelvis dated 09/07/11 and interpreted by M.D.
Admission report dated 09/11/11 from A.C.N.P.
Discharge summary dated 09/17/11 from M.D.
Preoperative physician's orders and physical examination dated 09/28/11
Notification of Adverse Determination from M.D. with dated 10/06/11
A letter "To Whom It May Concern" from with dated 11/02/11
An evaluation at with M.P.A.S., P.A.-C. and M.D. dated 11/09/11
A psychological prescreening from dated 11/09/11
A psychological evaluation/treatment request dated 11/15/11 from Dr.
Another Notification of Adverse Determination from, M.D. with dated 11/16/11
A preauthorization request from dated 11/28/11
Undated treatment plan for individual counseling sessions
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

A CT scan of the abdomen and pelvis on 03/31/11 revealed a questionable lesion within the right lobe of the liver near the dome of the liver and a 24 mm. adrenal adenoma. A total hip replacement was in good position and there was some area of sclerosis within

the right femoral head suspicious for avascular necrosis. The patient presented to the emergency room on 04/26/11 with complaints of right abdominal pain. The diagnoses were right groin pain and neuralgia. Gabapentin was prescribed. Another CT scan of the abdomen and pelvis was reviewed dated 04/26/11. The findings were similar to the previous study. A testicular ultrasound was performed on 05/12/11 and revealed small bilateral simple hydroceles and bilateral small varicoceles suspected with congested vasculature shown. Valsalva maneuver was not performed. A 4 mm. right epididymal head epididymal cyst or spermatocele. Dr. recommended an evaluation with a general surgeon on 05/20/11 after evaluating the patient and his diagnostic studies. On 05/20/11, Dr. diagnosed the patient with probably avascular necrosis with perhaps acute subchondral fracture causing severe pain. An arthrogram with diagnostic injection of the right hip under fluoroscopy was performed by Dr. on 05/25/11. Dr. evaluated the patient on 05/27/11. He felt the patient had a non-surgical condition and recommended anti-inflammatories, a short course of oral steroids, and outpatient pain management. On 06/07/11, Dr. evaluated the patient. He had exquisite tenderness and guarding in the medial aspect of the right anterior iliac spine, inguinal region, and right scrotal area. Dr. felt the patient might have an ilioinguinal nerve entrapment and neuropathy. An injection was recommended. Lyrica, Oxycontin, and Hydrocodone were prescribed. It was noted on 06/28/11 the injection had not been approved. The patient presented to the emergency room on 06/30/11 for abdominal pain. He was given Compazine and Norflex. On 09/07/11, he returned to the emergency room with right groin and testicle pain that had been more severe over the last four days. After reviewing the CT scan and laboratory data and the evaluation, the patient was diagnosed with severe right groin pain and osteonecrosis. He was transferred for observation on 09/11/11 for some inflammatory and infectious process possibly in the right inguinal hernia extending along the right spermatic cord. The patient was discharged from the hospital on 09/17/11 with Norco, Flomax, and Norvasc. On 10/06/11, Dr., on behalf of, provided a notification of adverse determination for the recommended procedure. On 11/09/11, Mr. prescribed Cymbalta, Hydrocodone, Xanax, and Ambien and recommended a psychological screening. On 11/16/11, Dr., on behalf of also provided a notification of adverse determination for the outpatient right inguinal nerve resection. Dr. recommended six sessions of individual counseling on 11/28/11.

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

First, it is a presumptive diagnosis that the patient is experiencing pain from the right inguinal nerve presumably as the result of an aggravation of this from a surgery he had

three years earlier. Doing a nerve resection in the absence of any significant objective evidence that this is the actual diagnosis is a bit aggressive and would be an irreversible procedure, in my opinion. The patient does have multiple images and multiple examinations which clearly show avascular necrosis of the femoral head and it appears that everyone examining the patient is in agreement that there is no hernia. He did have a diagnostic injection of the hip, although the results were never described. He has not had any trial of a right inguinal nerve block, which would be of low risk and very helpful in determining whether an inguinal nerve resection would be of any clinical benefit. Certainly, avascular necrosis of the femoral neck could present as severe inguinal pain. Inguinal nerve pathology is usually most evident shortly after inguinal surgery, so this makes this diagnosis somewhat less likely at this time. In summary, I do not believe it is appropriate at this time to consider any kind of permanent pain relieving procedures such as an inguinal nerve resection or neurolysis. His pain generator needs to be objectively determined prior to any further definitive treatment of any kind is provided. Therefore, the requested outpatient right inguinal nerve resection is neither reasonable nor necessary 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
- 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
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)