

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: January 13, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan of the pelvis.

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

The requested CT scan of the pelvis is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 12/8/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/20/11.
3. Notice of Assignment of Independent Review Organization dated 12/20/11.
4. History and Physical from Medical Center dated 11/5/08.
5. Operative Report from Medical Center dated 11/7/08.
6. Laboratory results from Medical Center dated 11/7/08.
7. Clinic notes from Medical Centers dated 11/23/11.
8. Clinic notes from MD dated 1/24/11.
9. Clinic notes from Physicians Pain Clinic dated 5/3/11, 2/14/11, and 10/14/10.
10. Clinic notes from dated 10/19/11 and 10/7/11.
11. Testicular Ultrasound from Diagnostic dated 11/8/11.
12. CT of the Abdomen and Pelvis dated 6/15/10 and 3/1/10.
13. Clinic notes from Surgical Group dated 2/3/10 and 1/28/10.
14. Denial letters dated 12/16/11, 12/13/11, and 12/2/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient presents with a history of recurrent bilateral inguinal hernia secondary to a work injury sustained on xx/xx/xx. The provider's notes of 11/5/08 document that the patient underwent bilateral inguinal hernia repair on 9/22/08, then presented on 10/15/08 with bilateral groin infection treated with antibiotics. On 10/30/08, the patient was found to have cellulitis and was treated with intravenous antibiotics. On 11/7/08, he underwent removal of mesh from both groins and placement of alternate mesh on the left. The patient continues to have chronic pain in the groin and testes. A testicular ultrasound on 11/8/11 was interpreted to show no evidence of herniation within the inguinal canals with a final impression of bilateral hydroceles. The provider has requested a CT scan of the pelvis to evaluate the anterior pelvic wall and the presence of residual mesh prior to a possible re-exploration for nerve entrapment syndrome. The Carrier has denied this service indicating that the requested CT scan is not medically necessary.

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

The stated indication for the pelvic CT scan is to evaluate the anterior pelvic wall and the presence of residual mesh prior to a possible re-exploration for nerve entrapment syndrome. It is not consistent with standard practice to obtain a CT scan if a triple neurectomy procedure is to be performed to eliminate the pain after inguinal surgery. Further, the submitted documentation does not demonstrate any other clinical indication for the requested pelvic CT scan. The patient's clinical history does not suggest a need to rule out hernia or infection. Nor is there documentation of any other findings that would support the need for a pelvic CT scan. All told, the medical records provided do not demonstrate that the patient meets Official Disability

Guidelines or standard of care for the requested study. Therefore, I have determined the requested CT scan of the pelvis is not medically necessary for treatment of the patient's medical condition.

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)

Poobalan, A. et al. A review of chronic pain after inguinal herniorrhaphy. *Clin J Pain*, 2003 Jan-Feb;19(1):48-54.

Bozuk, M., et al. Disability and chronic pain after open mesh and laparoscopic inguinal hernia repair. *Am Surg.*, 2003 Oct;69(10):839-41.