

Case Number:	CM13-0027892		
Date Assigned:	11/22/2013	Date of Injury:	12/11/2007
Decision Date:	01/24/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

Patient is a 28-year-old male who sustained an industrial injury on December 11, 2007. He worked for eight years as a driver and freight handler for [REDACTED]. The injury in question is a long complicated injury, but ultimately accepted that he suffered a right inguinal hernia when trying to move a dolly that connected two trailers. He attempted to avoid heavy lifting but ultimately, was forced to perform these activities. When performing them, he had a pulling or tearing sensation in his right groin. He was seen in an outpatient clinic and was diagnosed as suffering a right inguinal hernia, and underwent surgery for the first time on January 23, 2008, six weeks after the injury. He was released to return to full duty by the operating surgeon four weeks later. At that time, there was still a portion of the wound that had remained open. He used analgesics for pain, attempted to keep working. When he discontinued the analgesics, which he preferred to discontinue, he noted worsening pain in his right groin area. There was some swelling in the right groin area, as well as pain in his right testicle and swelling of the right testicle. On July 1, 2009, he was taken back to the operating room by his original operating surgeon. There he had exploration but no hernia repair and the mesh was left in place. Since that time on August 24, 2011, he had neurologic-like surgery, apparently a nerve transection, per [REDACTED] but is still having pain at that time. He continues to be followed by [REDACTED]. He has had local nerve block injections which cause some benefit for a short time. Otherwise he describes being quite limited due to pain and describes still having swelling in his testicle and incision site. He has not worked for six years.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ilioinguinal nerve blocks x 5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvic Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvic Chapter.

Decision rationale: The California MTUS is mute on this topic. According to Official Disability Guidelines (ODG) hip and pelvic chapter, Ilioinguinal nerve ablation is recommended for entrapment of the ilioinguinal nerve (hockey groin syndrome). The ilioinguinal nerve originates from the first lumbar spinal nerve. This nerve wraps above the iliac crest (upper ridge of hip bone) and travels into the groin. The "hockey groin syndrome," marked by tearing of the external oblique aponeurosis and entrapment of the ilioinguinal nerve, is a cause of groin pain in professional hockey players. Ilioinguinal nerve ablation and reinforcement of the external oblique aponeurosis successfully treats this incapacitating entity. (Irshad. 2001) Findings include varying degrees of tearing of the external oblique aponeurosis and external oblique muscle associated with ilioinguinal nerve entrapment. Repair of the external oblique tear, ablation of the ilioinguinal nerve, followed by a 12-week planned course of physical therapy allowed return to careers. (Lacroix. 1998) Regarding the request for additional ilioinguinal nerve block, Guidelines do not contain criteria regarding the use of ilioinguinal nerve blocks. Guidelines generally recommend that interventional procedures are considered effective if they result in specific reduction in pain, generally of at least 50% for an extended duration of time, resulting in functional improvement or reduction in medication use. It appears the patient has undergone approximately nine ilioinguinal nerve blocks thus far. It is unclear exactly how this "Series" of nerve blocks is being performed. Furthermore, there is no documentation of objective improvement or reduction in medication use as a result of the injections already provided. In the absence of clarity regarding those issues, the current request for additional nerve blocks is recommended for non-certification and the office visit is modified to one visit. Therefore the request for additional inguinal nerve block is not medically necessary

Office visit x 2: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Office Visits Section

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Office Visits Section.

Decision rationale: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The

need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Therefore the request for office visit x 2 is medically necessary.