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| Case Number: | CM13-0051967 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 07/15/2013 |
| Decision Date: | 06/20/2014 | UR Denial Date: | 10/30/2013 |
| Priority: | Standard | Application Received: | 11/15/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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 expert 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:

The mechanism of injury was "pushing a steel weighing at least 160 pounds when immediately following he noted a lump in the right groin. The date of injury is noted as 7/15/2013. On 7/15, he was doing heavy work doing something with a 160 pound weight at work. He was straining and felt a right groin lump and pain immediately thereafter. Over the next days he had nausea, vomiting, no passage of flatus and abdominal distention. He was admitted because of evidence suggesting a small bowel obstruction. A CT scan verified a partial small bowel obstruction. The right groin lump was not physically present. Apparently the patient was admitted. The date admitted is not clear. On 7/21 the patient complained of progressive abdominal pain with nausea and vomiting after the injury. He had a soft distended tender abdomen, slight tenderness in the right groin, and no peritoneal signs. A small left inguinal hernia was also noted on examination. A nasogastric tube was in place. Past medical history included a right inguinal hernia. On 7/22 the nausea was diminished. The abdominal was soft and distended. Initial labs on the 21st indicated a slight leukocytosis of 12.7. A CT Scan of the abdomen and pelvis apparently was consistent with a distal partial small bowel obstruction. The WBC was normalized on the 22nd. The patient was taken to surgery on the 23rd. Exploratory laparoscopy was done with lysis of adhesions in the region of the terminal ileum. The obstructed bowel was identified and was viable. A resection was not necessary. Bilateral inguinal hernias were identified with direct and indirect on the right and direct on the left. There was a lipoma of each cord. The trocar site was closed and open mesh repair of bilateral inguinal hernias was done. Lipomata were also removed.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXPLORATORY LAPAROTOMY WITH LYSIS OF ADHESIONS PERFORMED ON 7/23/2013: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27-28. Decision based on Non-MTUS Citation ODG, Surgery Guidelines, Laparoscopic Hernia Repair.

Decision rationale: California MTUS, ACOEM, and ODG do not contain criteria for exploratory laparotomy with lysis of adhesions. ODG does contain criteria for the use of surgical abdominal intervention for the treatment of hernia. These guidelines support the use of laparoscopic intervention for the treatment of hernia. To see if this case meets guidelines, one needs to reconstruct the history with the information at hand, the right groin lump was not physically present. In retrospect, this had been an incarcerated right inguinal hernia that had reduced itself. The fact that the incarcerated area was found and appeared to be somewhat strictured indicates that the incarceration had been there not just for a few hours but certainly longer. The adhesions also indicate that the incarceration was likely long-standing. The fact that the WBC was elevated on admission suggests either dehydration or possibly ischemic bowel secondary to the incarceration which had been the cause of this patient's symptoms immediately following the injury on the 15th. The care plan that was followed was appropriate and medically necessary. No further study or time was necessary. The surgeon had waited at least 48 hours without a change in the picture. As such, the currently requested exploratory laparotomy with lysis of adhesions was medically necessary.