

Case Number:	CM15-0190841		
Date Assigned:	10/29/2015	Date of Injury:	05/17/2000
Decision Date:	12/14/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Indiana, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 injured worker is a 55 year old female who sustained an industrial injury on May 17, 2000. The worker is being treated for: cervical and lumbar post laminotomy pain syndrome, obesity, major depressive disorder, right shoulder impingement syndrome, bilateral upper extremity entrapment neuropathy, narcotic dependence, bilateral knee internal derangement, left knee chondromalacia. Subjective: February 18, 2015 she reported having episodes of severe headaches with transient hemiplegia and difficulty with speech. She continues to report issue with urinary incontinence. Objective: February 18, 2015 noted severe dental loss and loss of dentation with mild facial droop, right. There is severe bilateral knee tenderness and positive patellar compression. There is note of the patient requiring treatment with plastic surgeon for ventral hernia repair and ongoing skin breakdown in the groin. July 01, 2015 noted the patient hospitalized with suicidal attempt with overdose of Lunesta. Diagnostic: UDS February 18, 2015 noted consistent with prescribed. Medication: July 01, 2015: noted "off all narcotics;" taking Prilosec for GERD. Treatment: pending urological evaluation, 2022 history of ACDF with pseudoarthritis and hardware loosening, cervical revision 2010, status post laminectomy 2002. On August 12, 2015 a request was made for treatment with plastic surgeon regarding ventral hernia repair and panniculectomy that was noncertified by Utilization Review on August 31, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ventral hernia repair and panniculectomy: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hernia; Ventral Hernia Repair.

Decision rationale: MTUS is silent on this, but ODG states: "Recommended in patients with pain and discomfort from the ventral hernia. See Surgery for more information and references. Either approach is recommended depending on surgeon experience and preference, but laparoscopic ventral hernia repair may offer lower complication rates and shorter length of stay than open repair. (Goodney, 2002) Monitoring instead of repairing an asymptomatic incisional hernia may be considered since the incidence in the general incisional hernia population of strangulation or incarceration of viscera in the hernia orifice may be less than 1%. (Nieuwenhuizen, 2007) A recent meta-analysis concluded that laparoscopic repair of ventral and incisional hernia is at least as effective, if not superior to, the open approach. (Forbes, 2009) Another recent RCT concluded that open surgical repair of ventral incisional hernias caused more complications but fewer serious adverse events compared to laparoscopic repair. According to the study, 30% of patients in the laparoscopic group and 9% in the open group had severe complications, including bowel injury, trocar site hernia, and sepsis with multisystem organ failure, but median time to return to work was 23.0 days in the laparoscopic group and 28.5 days in the open group. (Itani, 2010) Laparoscopic techniques have become more common in recent years, although the evidence is sparse. The short-term results of laparoscopic repair in ventral hernia are promising. In spite of the risks of adhesiolysis, the technique is safe. Nevertheless, long-term follow-up is needed in order to elucidate whether laparoscopic repair of ventral/incisional hernia is efficacious. (Sauerland, 2011) Recurrences after ventral hernia repair can be reduced significantly through the use of a component separation of parts augmented with onlay biologics, and this was most striking among smokers, for whom the use of biologics reduced the risk of recurrence by 41%. (Unadkat, 2011) Laparoscopic incisional hernia repair is as effective as open repair, with similar recurrence rates, according to this RCT. However, short-term benefits of laparoscopic incisional repair described in previous studies, eg, perioperative complications, operative time, and length of hospital stay, could not be confirmed. Long-term results and data on cost-effectiveness are necessary to make a more complete comparison between the two operative techniques, the authors concluded. (Eker, 2013) Laparoscopic surgery in obese patients had a significantly shorter median length of stay, lower total hospital charges, a lower overall complication rate, and lower rates of individual complications such as postoperative wound complications and postoperative pulmonary complications. The use of laparoscopic surgery in obese patients increased by more than 4-fold from 6.5% in 2008 to 28.0% in 2009, whereas that of open surgery decreased from 93.5% to 72.0%. (Lee, 2013) Laparoscopic repair of primary ventral hernias reduced the likelihood of surgical site infection by 85%, but patients spent an additional day in the hospital after the costly surgery and were more likely to suffer a persistent bulge at the hernia site." There is no evidence of pain or discomfort from the hernia. Therefore, the request for a ventral hernia repair and panniculectomy is not medically necessary.