

Case Number:	CM15-0086389		
Date Assigned:	05/08/2015	Date of Injury:	03/26/2007
Decision Date:	06/23/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/05/2015

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: Arizona

Certification(s)/Specialty: Surgery

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 58 year old male, who sustained an industrial injury on 3/26/2007. The mechanism of injury was not noted. The injured worker was diagnosed as having ventral, unspecified, hernia without mention of obstruction or gangrene. Treatment to date has included multiple hernia repairs, including an exploratory laparotomy, extensive lysis of adhesions, explanation of infected ventral hernia mesh, and complex abdominal wall reconstruction on 2/27/2013 (operative report submitted) and most recently, repair of midline hernia 10/29/2014 (progress report submitted). On 3/11/2015, he reported new abdominal pain and a new abdominal bulge. He reported that it started around late December and slowly worsened over time, worse with minimal activity, and causing significant discomfort. Physical exam noted a baseball-sized bulge in the right lower quadrant, which freely reduced when the injured worker was supine. Bowel sounds were noted when manually reducing the bulge, along with tenderness to palpation. Computerized tomography of the abdomen and pelvis on this day showed prior mesh ventral hernia repair with a small non-obstructed hernia in the right lower quadrant, protruding through the mesh and abutting the parietal peritoneum. A previously described fluid collection in the anterior abdominal wall was resolved. Prior total colectomy and ileoanal anastomosis, focal narrowing, wall thickening, and mucosal enhancement, with no proximal obstruction was identified. The treatment plan included recurrent ventral hernia repair, with lysis of adhesions and abdominal wall reconstruction, with 7 day inpatient admission.

IMR ISSUES, DECISIONS AND RATIONALES

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

Recurrent ventral hernia repair, lysis of adhesions, abdominal wall reconstruction:

Overtured

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 Chapter, Hernia Repair.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS is silent regarding ventral hernia. It is recommended that ventral and incisional hernias be classified before surgical therapy. The numbers of previous repairs and reducibility have been demonstrated to increase the risk of postoperative seroma. Number of previous repairs, morphology, size of hernia gap, risk factors (smoking, male gender, BMI, age, SSI and postoperative wound complications) and reducibility should be part of the classification system. Symptoms develop for 33-78% of patients with a ventral or incisional hernia. Emergency repairs are associated with high morbidity. The defect size of incisional hernias predicts recurrence rates. Symptomatic ventral and incisional hernias should be treated surgically. Suture repair is associated with a high recurrence rate. All defects of the abdominal wall should be repaired with the use of prosthetic mesh. Hernia recurrence is more likely with defects wider than 10cm. (Surgical Endoscopy (2014) 28:2-29) 2-26% of patients undergoing midline laparotomy develop incisional hernias. The choice of surgical technique remains controversial (open or laparoscopic repair and choice of mesh and fixation). (British J. of Surgery 2009; 96: 1452-1457).

Decision rationale: This is a difficult case in a patient who sustained a work related injury some time ago. He has crohn's disease and other comorbidities including diabetes and hypertension. His BMI is 25.9. He has had multiple abdominal operations for recurrent ventral hernias and currently presents with a new symptomatic recurrent incisional hernia. Although he may develop another recurrence or complication from the surgery especially given his history of multiple previous abdominal operations, since his hernia is symptomatic, it is reasonable to consider surgical repair. The choice of technique is dependent on the surgeon. Therefore, the requested treatment is medically necessary.

Inpatient admission for 7 days: Overtured

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Postoperative hospital stay can be predicted before the operation by evaluating certain factors related to the patient or procedure. Longer duration of surgery predict longer hospital stay in all types of ventral hernias where as strangulation, high ASA class, systemic-local postoperative complications, and type of repair procedures may

predict longer length of hospital stay in different ventral hernia types. (Chirurgia (Bucur). 2012 Jan-Feb; 107(1): 47-51).

Decision rationale: This patient has had multiple prior abdominal operations and therefore his surgery will be much more complex. The last operative note reported an extensive lysis of adhesions and I would expect the same or more for this one. I would anticipate a postoperative ileus. Depending on the complexity of the repair as well, the surgery would be expected to last longer and therefore one would predict a longer hospital stay. Additionally, his crohn's disease may make the surgery more complicated as well. Therefore, the requested treatment is medically necessary.