

<b>Case Number:</b>	CM15-0113808		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	07/18/2012
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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 (IW) is a 44-year-old female who sustained an industrial injury on 07/18/2012. Diagnoses include ilioinguinal neuralgia and status post right inguinal hernia repair. Treatment to date has included medications (norco, gabapentin), ilioinguinal nerve block and right iliopsoas injection. According to the progress notes dated 4/30/15, the IW reported increased pain level in the right groin, rated 8/10, which caused weakness in the legs, however there is no EMG study or documentation of such. She indicated that bearing down caused pain in the right lower abdomen. Medications helped decrease the pain. On examination, her gait was noted as mildly antalgic to the right. The records reflected the IW has had pain in the right groin since the hernia repair and it has progressively worsened. Exam shows no evidence of a recurrent hernia and pain with palpation of the groin, but difficult exam secondary to patient's obesity. A request was made for removal of hernia mesh, right inguinal region. The treating physician had mentioned getting a CT or MRI for further evaluation, but there is no record of these studies having been done.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Removal of Hernia Mesh, Right:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Medical Device Recall website.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation World J Gastrointest Surg. 2011 Jun 27; 3(6): 73-81. Current trends in the diagnosis and management of post-herniorrhaphy chronic groin pain. J Pain Research. 2014; 7: 277-290. Pain control following inguinal herniorrhaphy: current perspectives.

**Decision rationale:** Removal of the foreign body (mesh) alone has not been shown to relieve chronic groin pain. It is thought that it is due to chronic inflammation around the nerves from the mesh-induced reaction and the consequent degenerative nerve damage. Traditionally, surgical treatment of chronic groin pain includes groin exploration, mesh removal and neurectomy. Currently there are no long-term results available from large studies on the safety of surgical mesh removal with or without neurectomy. Recurrence and meshoma are obvious anatomic pathologies amenable to surgical correction. Meshoma may cause neuropathic pain from nerve entrapment, direct contact with mesh, or compressive effects. It may also cause nociceptive pain from compression of adjacent structures and foreign body sensation. Imaging is useful to help identify meshoma and involvement of adjacent structures. Operative removal of the meshoma is indicated with the need for simultaneous neurectomy directed by the type of mesh, approach, symptoms, imaging, and anatomy. If coexisting neuropathic pain is present, all nerves within the reoperative field should be addressed, as neuropathy cannot be assessed visually, and mesh removal will often compromise unaffected nerves within the inguinal canal. This patient does not demonstrate a recurrent hernia on examination. Additionally, there are no imaging studies to demonstrate a meshoma or evidence that the mesh would need to be removed. Mesh removal alone is also inadequate for treating post inguinal hernia repair pain based on literature review. Therefore, the prior utilization review is upheld. The surgery for mesh removal is not medically necessary and appropriate.