

<b>Case Number:</b>	CM13-0002223		
<b>Date Assigned:</b>	05/14/2014	<b>Date of Injury:</b>	08/01/2001
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	07/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/19/2013

### 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 Neurological Surgery, 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:

According to the records made available for review, this is a 72-year-old female with an August 1, 2001 date of injury and status post decompressive laminectomy at L4 and L5 with posterior lumbar interbody fusion and instrumentation March 3, 2003. At the time of request for authorization for extreme lateral interbody fusion (XLIF) L2-3, L3-4 with removal of hardware, posterior instrumentation T10 to S2, 3 day inpatient stay, assistant surgeon, thoracolumbosacral orthosis (TLSO) brace, bone growth stimulator, and post op physical therapy 12 sessions (on June 14, 2013), there is documentation of subjective (low back pain radiating to the right buttock with numbness and tingling, and severe persistent pain just below the previous incision at L4-L5) and objective (tenderness to palpation below previous extensive fusion due to facet arthritis at L5-S1; decreased motor strength in the left quads, right iliopsoas, right quadriceps, and right tibialis anterior; absent Achilles tendon reflex bilaterally and trace for the patella; and decreased sensation over the left lateral thigh, left lateral calf, and left medial and lateral foot) findings, imaging findings (CT of the lumbar spine (May 20, 2013) report revealed status post solid fusion at L4-5, osteopenia without acute bone injury; moderate canal stenosis and moderate right foraminal stenosis at L2-3; and retrolisthesis with disk-osteophyte complex causing moderate to severe central canal stenosis at L3-4), current diagnoses (adjacent segment disease L3-4 with severe stenosis, milder changes noted at L2-3, foraminal stenosis L5-S1, and solid fusion at L4-5), and treatment to date (activity modification, physical therapy, chiropractic treatment, lumbar epidural steroid injections, and medications).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EXTREME LATERAL INTERBODY FUSION (XLIF) L2-3, L3-4 WITH REMOVAL OF HARDWARE, POSTERIOR INSTRUMENTATION T10 TO S2: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, XLIF (eXtreme Lateral Interbody Fusion).

**Decision rationale:** MTUS does not address this issue. ODG identifies that XLIF (eXtreme Lateral Interbody Fusion) is not recommended due to insufficient evidence of the comparative effectiveness of XLIF versus conventional posterior lumbar interbody fusion or transforaminal lumbar interbody fusion. The request for extreme lateral interbody fusion (XLIF) L2-3, L3-4 with removal of hardware, posterior instrumentation T10 to S2 is not medically necessary or appropriate.

**3 DAY INPATIENT STAY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ASSISTANT SURGEON: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**THORACOLUMBOSACRAL ORTHOSIS (TLSO) BRACE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**BONE GROWTH STIMULATOR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**POST OP PHYSICAL THERAPY 12 SESSIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.