

<b>Case Number:</b>	CM15-0100609		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	09/23/2013
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic 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:

This injured worker is a 62-year-old male who sustained an industrial injury on 9/23/13. Injury occurred when he was struck by a semi-truck at his work site. He lost consciousness, and sustained blunt trauma to the face, head, arms, back and feet. Past medical history was positive for hypertension, depression, tinnitus and short-term memory loss. Past surgical history was positive for anterior lumbar interbody fusion at L5/S1, posterior fusion of L2 to L5, and revision in 2010 extending the fusion from L2 to the sacrum. Conservative treatment included medications, physical therapy, home exercise, pain management, and activity modification. The 3/10/15 lumbar spine MRI impression documented advanced disc degeneration at L1/2 with 3-4 mm posterior disc protrusion and osteophyte ridge complex, moderate to borderline moderately severe central canal stenosis in conjunction with posterior arch hypertrophy, and moderate bilateral foraminal narrowing. There were extensive postsurgical change with decompression laminectomy from L2 through S1 with posterior lumbar fusion and spinal instrumentation. There was substantial artifact, without evidence of significant spinal stenosis. The 4/24/15 treating physician report cited complaints of weakness, bilateral leg pain and paresthesias, right greater than left. He reported unsteadiness, required a cane for ambulation, and had sustained multiple falls. The most pronounced weakness affected his right ankle plantar flexion that contributed to his clumsiness while ambulating. Physical exam documented inability to toe walk, normal tandem gait, limited range of motion, 4-/5 knee extension and 4/5 knee flexion, extensor hallucis longus, and plantar flexion strength bilaterally. There was diminished sensation over the dorsum of the feet bilaterally. Lower extremity deep tendon reflexes were 0/4 and symmetrical. Bilateral straight leg raise was negative. Imaging was reviewed and showed prior decompression, fusion and instrumentation from L2 to S1. There was junctional stenosis at

L1/2 with advanced disc degeneration, severe central canal stenosis, bilateral foraminal narrowing, and a disc osteophyte complex. X-rays demonstrated solid anterior interbody fusion at L5/S1, implants with a pedicle screw rod construct extending from L2 to the sacrum, and add-on rods with a side-to-side connector from L5 to the sacrum. The scoliosis series demonstrated a mild 9-degree scoliosis from T11-L1, collapsed disc and forward lean at L1/2, with wide lateral osteophyte formation at that level and advanced degenerative changes. The diagnosis included proximal junctional stenosis at L1/2 with progressive neurogenic claudication, mild kyphosis and scoliosis. The treatment plan recommended a lateral approach and restoration of lordosis at L1/2 with hyperlordotic PEEK cage and bone morphogenetic protein, and posterior instrumentation as an add-on construct to restore his sagittal vertebral alignment from T10 to L2. Authorization was requested for XLIF (extreme lateral interbody fusion) L1/2, revision T10-L4 laminectomy, instrumentation and fusion. The 5/4/15 utilization review non-certified the request for XLIF L1/2 and revision T10-L4 laminectomy, instrumentation and fusion as there was no current evidence based medical guidelines support for the XLIF and no discussion as to why the standard posterior approach could not be completed for this injured worker.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **XLIF (extreme lateral interbody fusion) Lumbar L1-L2, Revision (thoracic) T10-L4 (lumbar) - Laminectomy Instrumentation and Fusion: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion, endoscopic; XLIF (extreme lateral interbody fusion).

**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 Lumbar & Thoracic: Fusion (spinal); XLIF (eXtreme Lateral Interbody Fusion); Fusion for adult idiopathic scoliosis.

**Decision rationale:** The California MTUS does not provide recommendation for extreme lateral interbody fusion (XLIF). The Official Disability Guidelines state that XLIF is not recommended. A recent systematic review concluded that there is insufficient evidence of the comparative effectiveness of XLIF versus conventional posterior lumbar interbody fusion or transforaminal lumbar interbody fusion. Additional studies are required to further evaluate and monitor the short and long-term safety, efficacy, outcomes, and complications of XLIF procedures. The ODG guidelines recommend fusion for adult idiopathic scoliosis when significant deformity is present. Criteria include 3 months of non-surgical care (education, exercises, and anti-inflammatory medications), curvatures over 50 degrees with persistent pain in adults, progressive mid and low back curve or low back curve with persistent pain, reduced heart and lung function, and adults under 50 years old due to surgical risks, but exceptions are possible. Guideline criteria have not been met. This injured worker presents with junctional stenosis at L1/2 with severe central canal stenosis and advanced disc degeneration. There is radiographic evidence of a mild scoliosis at T11-L1. There is no compelling rationale provided to support the medical necessity of the requested XLIF approach over traditional posterior spinal fusion. Therefore, this request is not medically necessary.