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March 7, 2018, amended June 22, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Extreme Lumbar Interbody Fusion and Posterior Lumbar decompression and fusion

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a Board Certified Doctor of Orthopedic Surgery with over 18 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX: MRI Lumbar Spine without Contrast interpreted by XXXX. **Impression:** 1. At L4-5, moderate spinal canal stenosis secondary to a central disc protrusion. 2. At L5-S1 mild spinal canal stenosis and moderate bilateral neural foraminal stenosis secondary to a central disc protrusion superimposed upon a wide disc bulge.

XXXX: Progress Note by XXXX. **HPI:** This is a XXXX complaining of a sharp throbbing lumbar pain since XXXX. At the time XXXX was at work when XXXX. By the next day the lumbar pain worsen and XXXX reports to have been evaluated by a chiropractor who used an inversion table and massage which helped some of the symptoms. As the pain continued XXXX was re-evaluated at XXXX where XXXX received PT at first and as the symptoms continued a lumbar MRI demonstrated a herniated disc. XXXX was referred to pain management. XXXX performed a bilateral L4-5 epidural injection on XXXX that improved 100% of the leg symptoms and 50% of the lumbar pain. The lumbar pain is now constant and variable with a sharp throbbing and slight pain to changes from 4-8/10 and makes up 70% of the symptoms. Today pain is 9/10. Aggravated by lifting, rapid movements, extension, prolonged sitting or standing. Alleviating conditions include lying down, stretching or stretching legs. The patient is able to walk up to 50 feet due to the lumbar pain. The remaining 30% of symptoms include a bilateral legs sharp electrical pain that is greater on the right. Presentation pattern is same as lumbar pain but it remains intermittent and variable. Symptoms worsen and radiate along the buttocks, lateral pelvis, anterior thigh, medial thigh and medial lower leg. The left lower extremity pain radiates from the posterior thigh to the right lower leg. The right lower extremity radiates to the anterior leg down to the medial lower leg. The baseline pain changes from 0-10/10. Today pain is 9/10. On XXXX we requested a follow up bilateral L4-5 epidural injection to be both diagnostic and therapeutic. Patient states XXXX is now using a cane. **Exam:** Palpation: there is bilateral paravertebral muscular tenderness. ROM: XXXX can bend forward to the ankle level. There is pain with forward flexion, extension from a forward flexion position, extension, right rotation and left rotation. Negative Patrick test, Gaensien's sign and pelvic tilt test. Deep tendon reflexes: Patellar L2, L3, L4 (R) 2/4 (L) 2/4. Posterior Tibialis-L5 (R) 0/4 (L) 0/4. Achilles-S1 (R) 1/4 (L) 2/4. **Assessment:** Lumbar Sprain. **Plan:** Restrictions,

home exercise, lose weight, bilateral L4-5 transforaminal epidural injection with selective nerve root block. The patient received a prescription for XXXX. We discussed an extreme lateral interbody fusion with or without open reduction internal fixation. The patient wishes to proceed with surgery. A lumbar CT scan will be done for preoperative planning.

XXXX: Progress Note by XXXX. We received a denial for the previously requested surgical procedure with the rationale that no instability is demonstrated or any other prior images. Dynamic imaging of the lumbar spine was performed on this patient and it clearly demonstrated a 6mm shift at L4-5 and a 3mm shift at L5-S1 between flexion and extension. With these new radiological findings we would like to submit for a reevaluation on the previously requested L4-5 X-LIF and a L4-S1 P-LIF.

XXXX: UR performed by XXXX. **Rationale for Denial:** As noted in the ODG, a lumbar fusion surgery can be supported if there is specific objective evidence of a spondylolisthesis, unstable fracture, dislocation, acute spinal cord injury with post-traumatic instability. Noting none of these diagnoses has been intensified, noting that here is no specific objective data demonstrating infection, instability, or fracture. There is insufficient clinical data presented to support this request. Therefore, this is not clinically indicated.

XXXX: UR performed by XXXX. **Rationale for Denial:** The ODG state that an extreme lateral interbody fusion is not recommended. It was noted that radiographs were reviewed and revealed spondylolisthesis at L4-5 and L5-S1. The patient was also previously treated with massage, physical therapy, chiropractic care, injections, and medications. However, the guidelines specifically do not recommend this procedure. Three were no exceptional factors noted that would warrant the procedure outside of the guideline recommendation. The request also did not specify the levels or if the procedure was inpatient or outpatient. As such, the request for Reconsideration of extreme lateral interbody fusion for the lumbar spine, unspecified inpatient/outpatient is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for extreme lumbar interbody fusion (XLIF) and posterior lumbar decompression and fusion is denied.

The Official Disability Guidelines (ODG) does not recommend XLIF. There is insufficient evidence to support XLIF over conventional posterior lumbar interbody fusion or transforaminal lumbar interbody fusion.

This patient has pain in the lower back and legs. XXXX has spondylolisthesis at L4-5 and L5-S1. There are no unusual circumstances in this case to support XLIF as a superior procedure to more traditional approaches to lumbar fusion.

Therefore, the request is not medically necessary and the denial is upheld.

Per ODG: XX

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**