

<b>Case Number:</b>	CM13-0022812		
<b>Date Assigned:</b>	11/15/2013	<b>Date of Injury:</b>	12/14/1998
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2013

### 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 Physical Rehabilitation & Pain Management has a subspecialty in Interventional Spine 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:

The patient is a 70-year-old male with a date of injury of 12/14/1999. According to progress report 08/18/2013, the patient is status post L3-L4 epidural injection on 03/22/2013, which provided 80% pain relief of low back and 75% of leg pain. Functional ability has increased "moderately" with increase in activity level and endurance, but patient now reports cervical symptoms. The patient has declined spinal surgery and wishes to proceed with spinal cord stimulator. Examination revealed lumbar spine revealed, "Range of motion has improved. Strength, not able to heel-toe walk." Straight leg raise is negative. Examination of the cervical spine revealed, sensation is decreased in the left arm at C6, and Spurling's test is positive. The listed diagnoses are: 1. Lumbar radiculitis. 2. Lumbar disk bulge at L3-L4 with nerve root impingement. 3. Cervical radiculitis. 4. Cervical post-laminectomy syndrome. 5. Psychological clearance obtained for spinal cord stimulator. Treating physician is requesting electric scooter to aid in transportation and a topical compound cream. Utilization review denied the request on 08/22/2013. Treatment reports from 03/07/2013 through 08/08/2013 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electric Scooter (3 Wheel Go-Go Victory 9): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices, Page(s): 99.

**Decision rationale:** This patient presents with chronic low back pain. The treating physician is requesting an electric scooter (3 wheeled Go-Go Victory 9) to aid in transportation. Power Mobility Devices under MTUS pg 99 states, "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." It is unclear why the treating physician is requesting an electric scooter for aid in transportation, as there are no issues documented with the patient's mobility. It was noted the patient has 80% pain relief from an epidural steroid injection, and patient's ability has increased in "activity and endurance." In addition, there are no documentation of upper extremity problems where a wheelchair cannot be considered. MTUS allows for power mobility devices when manual w/c is not feasible due to upper extremity weakness and no one is available for help. Such is not demonstrated in this case. Therefore, the request is not medically necessary.

**Ointment; Ketamine, Gabapentin, Ketoprofen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Regarding Topical Creams, Topical Analgesics Page(s): 111.

**Decision rationale:** This patient presents with chronic low back pain. The treating physician is requesting a musculoskeletal ointment; ketamine, gabapentin, and ketoprofen. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Under Ketoprofen, MTUS states, "This agent is not currently FDA approved for a topical application." Furthermore, Gabapentin is not recommendation in any topical formulation. Therefore, the request is not medically necessary.