

<b>Case Number:</b>	CM14-0020944		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	06/19/2005
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 56 year-old female who reported an injury on 06/19/2005 from unknown mechanism. The injured worker had a history of bilateral knee pain. Upon examination of the on 12/30/2013 the injured worker was favoring her wrist bilaterally, decrease range of motion of the wrist with no obvious tactile allodynia, hyperpathia, cyanosis, or edema, moderate to severe pain with manipulation of the wrist bilaterally that extended to the forearms, shoulder pain bilaterally knee pain without evidence of neuralgia or sympathalgia. The injured worker had a diagnoses of bilateral wrist injury, bilateral knee pain, possible upper extremity neuralgia, and chronic opiate therapy for pain, reactive severe depression/anxiety secondary to pain, obesity and severe GI distress secondary to pain. There was no treatment recommended on 12/30/2013. The medications were Norco 10/325mg, Cymbalta 60mg, Oxycodone 5mg, Prilosec 20mg, and Ibuprofen 600mg. The treatment plan was a request for a stationary bike for home use. The request for authorization form was not provided within the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF A LOW IMPACT STATIONARY BIKE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Exercise equipment.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) recommends passive therapy for short-term relief during the early phases of pain treatment to reduce inflammation and swelling. Active therapy is indicated for restoring flexibility, strength, endurance, function, range of motion and to alleviate discomfort. Patients are expected to continue active therapies at home. The recommended schedule for myalgia and myositis, unspecified allows for 9-10 visits over 8 weeks. The requested therapy does not specify any modalities, body parts to be exercised and exceeds the recommendations. Therefore the request for physical therapy, two times ten, total twenty is not medically necessary and appropriate.