

<b>Case Number:</b>	CM14-0147575		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	11/19/2013
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	08/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 42-year-old male who reported an injury on 11/19/2013 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his left knee that ultimately resulted in anterior cruciate ligament reconstruction, high tibial osteotomy and meniscal repair. The injured worker was treated post surgically with physical therapy. The injured worker was evaluated on 08/12/2014. It was documented that the injured worker was regaining strength with physical therapy, but was still symptomatic with weakness. The injured worker's diagnoses included sprain/strain of the collateral ligament, and sprain/strain of the cruciate ligament. The injured worker's physical examination documented that there was a mildly positive Lachman's test and range of motion described as -5 degrees in extension to 125 degrees in flexion. The injured worker's treatment plan included additional physical therapy and a prescription for a stationary bike to assist with therapy at home. No Request for Authorization form was submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Med Equipment: Stationary Bike Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise  
Page(s): 47.

**Decision rationale:** The request for Durable Med Equipment: Stationary Bike Purchase is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend 1 type of exercise program over the other. The clinical documentation submitted for review does indicate that the injured worker is participating in postoperative physical therapy. The injured worker should be well versed in a home exercise program. There is no documentation that the injured worker is not successfully participating in a home exercise program and requires additional equipment within the home. Therefore, the need for a stationary bike is not supported in this clinical situation. As such, the requested Durable Med Equipment: Stationary Bike Purchase is not medically necessary.