

<b>Case Number:</b>	CM15-0001945		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	07/09/2013
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 58-year-old male who reported an injury on 07/09/2013. He was pulling a box, and the rope handle broke, which forced him to fall backwards, landing on his right hand. On 05/21/2014, the injured worker presented for a follow-up. Prior therapy included surgery, physical therapy, and medications. The injured worker notes right wrist, hand, and upper extremity pain with radiation to the 3rd, 4th, and 5th right hand fingers. There are reports of numbness and tingling to the right hand, along with weakness, loss of strength, and mobility. Current medications included Losartan, NSAID medications and as needed for pain when necessary. Diagnoses were status post impaction crush injury, right wrist in forced palmar flexion, status post open distal right radius fracture, status post ORIF of right distal radius fracture, status post right distal radius fracture, right forearm loss of supination, right chronic wrist pain, right wrist loss of range of motion, right thumb loss of range of motion, carpal tunnel syndrome, status post wrist 4 portal arthroscopy and debridement, synovectomy, and right 4th finger intrinsic tightness. The provider recommended a DVT device. There was no rationale provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DVT device:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Venous thrombosis.

**Decision rationale:** The request for a DVT device is not medically necessary. The Official Disability Guidelines state that for deep venous thrombosis it is recommended that prophylactic measures are a consideration for anticoagulation therapy for those who are at high risk of developing a venous thrombosis. No evidence that the injured worker is at a high risk of developing a venous thrombosis. Additionally, the site at which the DVT device was indicated for was not specified in the request as submitted. As such, medical necessity has not been established.