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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX- XX XX XX XX; XXXX 5% topical patches #2 boxes of 15 (Refills X 4); XX Support

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XXXX with history of an XX claim from XXXX. The mechanism of injury was not detailed in the information provided for review. The pertinent prior treatments included medications. The patient underwent a XX XX XX at XX-XX in XXXX. The physician office visit on XXXX revealed the patient had subjective complaints of XX XX XX, XX XX XX and XX XX XX pain rated XX-XX/XX. The symptoms were unchanged since their last evaluation. The patient also complained of XX XX pain and XX XX XX pain in the XX XX. The current medication included XXXX. The physical examination revealed pinprick sensation was decreased in the XX XX XX. The patient had decreased strength in the XX XX, XX XX XX, and XX XX rated XX+/XX and in the XX XX rated X-/X. The XX XX and XX XX were XX+/XX. The gait was X. Straight leg raises while seated was positive XX for radiating leg pain. The diagnoses included XX XX, XX XX spine status XX XX XX XX, XX XX without XX, XX XX, XX secondary to XX XX displacement, and XX XX XX. The patient denied side effects from medications. The patient was given a XX XX XX/XX XX XX. Additionally, the physician requested a XX XX XX purchase and a refill of XXXX patches. The patient was to use the medication as needed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The Official Disability Guidelines indicate that XX XX XX are not recommended except for patients who have a XX XX injury. The physician documentation indicated the request was made for a XX XX XX (XX), not in an XX. The rationale for the use of an XX Device was not noted. There were no exceptional factors to warrant nonadherence to guideline recommendations. The XX is not supported. The Official Disability Guidelines indicate that XXXX patches are recommended for patients who have localized pain consistent with a XX etiology. There should be documentation of a trial and failure of a XX or XX XX or an XX such as XXXX. The patient had been utilizing XXXX. The patient had also been utilizing XXXX patches. There was a lack of documentation indicating the patient had adequate pain relief and adequate functional improvement with use of the medication. Therefore, the XXXX topical patches are not supported. Additionally, a refill ×4 is not appropriate without documentation of efficacy. The Official Disability Guidelines indicate that XX XX devices are not recommended. XX XX decompression for the treatment of XX XX injuries is not recommended. While XX XX is recommended to treat XX fractures and XX, documented instability and nonspecific XX XX pain, the physician fitted the patient with a XX XX XX device, which is not recommended.

Given all of the above, the prior determination regarding the requested XX - XX XX Stim XX XX; XXXX 5% topical patches #2 boxes of 15 (Refills x 4); XX Support is not medically necessary and therefore upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, XX XX Chapter XX XX XX (XX) Not recommended except for specific criteria below. See also XX XX (XX-XX).