

# Pure Resolutions LLC

An Independent Review Organization

Phone Number:  
(817) 779-3288

990 Hwy. 287 N. Suite 106 PMB 133  
Mansfield, TX 76063

Email: [pureresolutions@irosolutions.com](mailto:pureresolutions@irosolutions.com)

Fax Number:  
(817) 385-9613

## Notice of Independent Review Decision

Case Number:

Date of Notice: 12/07/2015

### Review Outcome:

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

### Description of the service or services in dispute:

Voltaren Gel 1%, 5 tubes/month X 1 year

**Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:**

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

### Patient Clinical History (Summary)

Patient is a female. On 08/13/15, a preauthorization request was submitted for this patient for Voltaren gel 1% five tubes and it was noted then the patient could not take oral NSAIDs due to cardiac risk.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

On 08/21/15, a utilization review determination was submitted for the requested Voltaren gel, five tubes per month times one year, and it was noted there was lack of documentation indicating the patient had developed osteoarthritis in the knee to warrant the use topical NSAIDs, and there was lack of documentation indicating the need for topical formulation over a tablet form. It was also noted that long term use of topical NSAIDs is not recommended as the guidelines recommend short term use of one to two weeks or four to 12 weeks for arthritis and tendinitis. Additionally, the refills would not be indicated as it did not allow for reassessment in between the prescriptions to determine efficacy or change in treatment options. Therefore the request was non-certified. Official Disability Guidelines were utilized as a reference source.

On 09/30/15, a utilization review report per the requested Voltaren gel 1%, five tubes per month times one year, was non-certified. Official Disability Guidelines pain chapter was the reference source, and it was noted that long term medication for osteoarthritis is acetaminophen and the patient was status post totally arthroplasty and no longer had an arthritic knee and there was no documentation what currently ongoing objective identifiable pathology would require the use topical NSAIDs. Therefore the request was non-certified.

No clinical notes were submitted for this review. There is no indication that the patient has osteoarthritis, and no indication that the patient has pain or inflammation. This type of medication is recommended for short term use, and may be recommended if there is documented failure of lesser measures.

The official disability guidelines state Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations.

Therefore is the opinion of this reviewer the quest for Voltaren gel 1% five tubes per month times one year is not medically necessary and the prior denial are upheld.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)