

<b>Case Number:</b>	CM13-0006306		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/13/2009
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	07/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/02/2013

### 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 Orthopedic Surgery and is licensed to practice California. 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:

This is a 41 year old male with a 3/13/09 injury date. The patient sustained an industrial right knee injury and underwent right knee arthroscopy in 2009. In an 8/15/12 QME supplemental report, [REDACTED] discussed the possibility of psoriatic arthropathy and, if confirmed, the possible treatment with methotrexate. It was noted that the patient does have a history of psoriasis and gout. In a 1/4/13 AME supplemental report, [REDACTED] expresses the desire for the patient to have a repeat arthroscopy because MRI studies are not the "gold standard" in defining underlying pathology, and the patient continues to have persistent pain, swelling, and dysfunction. A right knee MRI from 9/1/10 was described by the physician as showing localized full-thickness cartilage fissuring along the medial aspect of the medial patellar facet, mild to moderate cartilage thinning, and a moderate large effusion within the knee joint. The lateral meniscus appeared to be slightly blunted, appearing borderline suspicious for a subtle tear at that level, but the medial meniscus was normal. In a 5/2/13 follow-up, the patient had continued pain and swelling in the right knee and there was tenderness to palpation at the joint line. Diagnostic impression: right knee inflammatory arthritis. Treatment to date: right knee arthroscopy (July 2009). A UR decision on 7/23/13 denied the request for repeat right knee arthroscopy on the basis that there were no current imaging findings of a surgically correctable lesion or inconclusive findings. In addition, the records did not provide an indication that the patient has current positive exam findings to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REPEAT RIGHT KNEE ARTHROSCOPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator based their decision on the MTUS ACOEM, Chapter 13 Knee Complaints, page 343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter--Diagnostic arthroscopy. Other Medical Treatment Guideline or Medical Evidence: Helliwell PS, Taylor WJ. Classification and diagnostic criteria for psoriatic arthritis. Ann Rheum Dis. 2005;64:ii3-ii8.

**Decision rationale:** CA MTUS does not support arthroscopic surgery in the absence of objective mechanical signs, such as locking, popping, giving way, recurrent effusion or instability, and consistent findings on MRI. In addition, ODG criteria for diagnostic arthroscopy include persistent pain and functional limitations recalcitrant to conservative care, when imaging is inconclusive. However, the patient's right knee MRI from 2010 does not show a surgically correctable lesion. In the very limited documentation that is available for this case, the providers seem to indicate the desire for a repeat arthroscopy for the purpose of obtaining a synovial biopsy, but this is not explicitly stated. Presumably the biopsy would help in the work-up of inflammatory arthritis, which would make sense given the patient's history of gout and psoriasis. However, the article by Helliwell et al points out that the diagnosis of psoriatic arthritis can be made on clinical and radiographic grounds alone. Although a synovial biopsy can be helpful in the diagnosis, it is often not essential. As an alternative to biopsy, synovial fluid can be aspirated from the joint, and in the setting of psoriatic arthritis it will show inflammatory synovial fluid with a normal or increased C3 or C4 level and an absence of infection or crystals of monosodium urate or pyrophosphate. Nonetheless, based on the limited documentation, it is a reach to assume that the providers are trying to obtain a synovial biopsy. The medical necessity of the requested procedure has not been established at this point. Therefore, the request for Repeat Right Knee Arthroscopy is not medically necessary.