Medical Assessor Guidance Note – Number 9

Musculoskeletal System: Upper Extremity Impairment

Assessment of Resection Arthroplasty

This material is issued by the Motor Accidents Authority under s.65 (2) of the *Motor Accidents Compensation Act 1999* (the Act) in the interests of promoting accurate and consistent medical assessments under the Act. The interpretation provided here is not legally binding but represents the clinically recommended interpretation in an area where more than one interpretation of existing provisions may be possible. This recommended interpretation is publically available. Any medical assessment which does not adopt this interpretation should be accompanied by clinical justification for the interpretation adopted, supported by full, robust reasons.

Reference

The Motor Accidents Authority Permanent Impairment Guidelines 1 October 2007 **(MAA Guidelines):** Chapter 2 Clause 2.17, page 12.

The American Medical Association Guides to the Evaluation of Permanent Impairment, 4th edition **(AMA 4 Guides):** Chapter 3 section 3.1m Impairment Due to Other Disorders of the Upper Extremity page 58, Table 27 page 61.

Background

According to the AMA 4 Guides page 62:

> *"In the presence of decreased motion, motion impairments are derived separately... and combined with arthroplasty impairments using the Combined Values Chart...".*

This must be taken in context with the preamble to section 3.1m, page 58, which states:

> *"...It is emphasized that impairments from the disorders considered in this section are usually estimated by using other criteria. The criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairments...".*

Issue requiring clarification

The AMA 4 Guides Table 27 (page 61) indicates that some resection arthroplasties are designated 'isolated'. There is no definition of the meaning of "isolated" in the context of Table 27 but the implication appears to be that the impairment rating for a resection arthroplasty is not applicable if the resection arthroplasty is part of a more complex procedure.

Preferred interpretation

The AMA 4 Guides Table 27 indicates that some resection arthroplasties equate with a specific degree (%) of upper extremity impairment only if they are 'isolated' (and therefore not part of another procedure). Isolated resection arthroplasty of the distal clavicle falls into this category and results in 10% upper extremity impairment.

If a resection arthroplasty designated 'isolated' (for example a resection arthroplasty of the distal clavicle) is part of another more complex procedure (for example, a rotator cuff repair) the resection arthroplasty does not result in any additional impairment. The impairment is assessed based on other criteria only (for example, range of movement).

In summary therefore, a resection of the lateral end of the clavicle associated with a rotator cuff repair should not be assessed by combining the impairment relating to lack of range of movement with the impairment rating for the resection arthroplasty. Only the impairment rating for the lack of range of movement should be applicable.

Medical Assessors should carefully review the relevant surgical reports to ensure that the documentation provides unambiguous information on the pathomechanics of the injured joint or limb and associated treatment.

Case examples:

1. A motorcycle rider was knocked from his bike and landed heavily on his right shoulder. Investigations revealed a fracture to the distal clavicle involving the AC joint. Investigations of the right shoulder revealed no abnormality. The fracture healed but he developed osteoarthritis of the right AC joint with severe constant pain. A resection of the distal clavicle was performed. At assessment residual pain was reported in the area of the resection but there was no tenderness over the glenohumeral joint Movements in the right shoulder were slightly decreased at end of range due to AC joint pain.

   The diagnosis was an isolated AC joint injury with no glenohumeral (shoulder) joint injury. The assessment of the AC joint injury from Table 27 was 10% UEI (6% WPI). There was no assessment for decreased range of movement as this was considered as double dipping for the same pathology...

2. A pedestrian was struck by a car and knocked to the road, falling onto her outstretched left arm. She immediately noted pain in her left shoulder. Examination soon after the accident revealed tenderness over the anterior and lateral aspect of the left shoulder. A positive impingement test was noted. Investigations revealed a large partial thickness tear to the supraspinatus tendon as well as subacromial/subdeltoid bursitis. A rotator cuff repair was carried out and a resection of the distal clavicle to relieve impingement.

   The diagnosis was a rotator cuff injury with surgical repair. There was no evidence of injury to the AC joint. The assessment of the left shoulder was carried out from the decreased range of movement which was the most appropriate method of assessment for the rotator cuff injury. No assessment for the resection arthroplasty

was combined with the range of movement assessment as this would have been a duplication of impairment for the one pathology.

3. The driver of vehicle was involved in a head on collision. He was wearing a seat belt and sustained an injury to the right shoulder. Investigations revealed a subluxation of the AC joint as well as a tear to the supraspinatus tendon and a labral tear. Arthroscopic repair of the rotator cuff and labral tear was carried out as well as excision of the distal end of the clavicle due to ongoing AC joint subluxation and pain.

The diagnosis was a rotator cuff injury with a tear to the glenoid labrum with a separate injury to the AC joint. The assessment was made by combining the impairment from the decreased range of movement in the right shoulder with 10% UEI (from Table 27). This was due to separate pathology in the shoulder and the AC joint and was not a duplication of impairment from a single pathology.

Justification for preferred interpretation

The relevance of the designation 'isolated' for certain excision arthroplasties in the AMA 4 Guides Table 27 has frequently not previously been recognised.

The preferred interpretation and methodology is suggested to promote consistency of assessment.

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