STATE OF VERMONT
DEPARTMENT OF LABOR

Robert Brown

v.

W.T. Martin Plumbing & Heating

Opinion No. 14-10WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Patricia Moulton Powden
Commissioner

State File No. Y-52948

OPINION AND ORDER

Hearing held in Montpelier, Vermont on November 25, 2009
Record closed on January 5, 2010

APPEARANCES:

J. Norman O'Connor, Esq., for Claimant
Jeffrey Spencer, Esq., for Defendant

ISSUE PRESENTED:

What is the appropriate permanent impairment rating attributable to Claimant's August 30, 2006 work injury?

EXHIBITS:

Joint Exhibit I: Medical records

Claimant's Exhibit 1: Deposition of Robert Giering, M.D., taken on November 3, 2009
Claimant's Exhibit 2: *Curriculum vitae*, Todd Lefkoe, M.D.

Defendant's Exhibit A: Dr. Wieneke reports, 3/17/08 and 5/20/09

CLAIM:

Permanent partial disability benefits pursuant to 21 V.S.A. §648
Interest, costs and attorney fees pursuant to 21 V.S.A. §§664 and 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his employer as those terms are defined in Vermont's Workers' Compensation Act.

2. Judicial notice is taken of all relevant forms contained in the Department's file relating to this claim. Judicial notice also is taken of the *AMA Guides to the Evaluation of Permanent Impairment (5th ed.)*(the *"AMA Guides"*).

3. Claimant worked as a master plumber for Defendant, a plumbing contractor. On August 30, 2006 he slipped and fell down a flight of stairs at a job site. Claimant injured his right shoulder in the fall.

4. Claimant suffered a right shoulder rotator cuff tear, which Dr. Nofziger, an orthopedic surgeon, surgically repaired in January 2007. Thereafter, Claimant underwent a course of physical therapy. His recovery was complicated by adhesive capsulitis as well as symptoms indicative of complex regional pain syndrome (CRPS).

5. Complex regional pain syndrome is a disorder of the sympathetic nervous system. One of the hallmark characteristics of the syndrome is burning pain that does not follow a single nerve root distribution but rather is generalized throughout the affected limb. Beyond that general characteristic, the signs and symptoms of CRPS can be grouped into four general categories:

    - Hyperesthetic pain, that is, pain that is disproportionate to what would be expected from the inciting injury, and/or allodynia, meaning pain in response to a light touch or stimulus that is not normally painful;

    - Vasomotor changes, such as changes in skin color and/or temperature in the affected limb as compared to the unaffected limb;

    - Sudomotor changes, which may be manifested by edema, swelling and/or sweating in the affected limb as compared to the unaffected limb; and

    - Motor changes, such as decreased range of motion and/or motor dysfunction (weakness, tremors, or sustained muscle contractions), and trophic changes involving abnormal nail and/or hair growth.

6. These symptoms do not always occur concurrently or consistently, but rather often wax and wane repeatedly over time, and may vary greatly from patient to patient. Aggressive treatment in the early stages of CRPS typically leads to a better outcome, as does continued use of the affected limb to the fullest extent possible.

7. As treatment for Claimant's adhesive capsulitis, in April 2007 Dr. Nofziger performed a second surgical procedure, in which he manipulated Claimant's shoulder under anesthesia. Claimant gained some shoulder motion thereafter, but his CRPS symptoms persisted. These included burning pain and diffuse weakness in his right arm, intermittent redness, sweating, temperature changes, swelling and decreased sensation in his right hand, and muscle contractions in his right fingers.

8. At Dr. Nofziger's referral, Claimant treated for his CRPS symptoms with Dr. Giering, a physiatrist and pain management specialist. Dr. Giering first examined Claimant in April 2007. He confirmed both that Claimant did indeed suffer from CRPS and that the condition was causally related to his August 2006 work-related fall.[1]

9. Dr. Giering testified that he arrived at his CRPS diagnosis by referring to the diagnostic criteria published in 1999 by the International Association for the Study of Pain (IASP). Those criteria require that in order for a CRPS diagnosis to be made, a patient (a) must report at least one symptom in each of the four categories listed in Finding of Fact No. 5 above; and (b) must exhibit at least one sign in two or more of the categories.[2]

10. Dr. Giering has treated Claimant continuously since April 2007. As his medical records reflect, Claimant has reported sufficient symptoms, and Dr. Giering personally has observed sufficient signs, to satisfy the IASP-established diagnostic criteria for CRPS. Other medical providers have recorded their observations as well, all of which tend to support the diagnosis.

11. In June 2008 Dr. Giering determined that Claimant had reached an end medical result. Because he was not proficient in rating permanency in accordance with the *AMA Guides*, Dr. Giering referred Claimant to his colleague, Dr. Lefkoe, for this purpose. Dr. Lefkoe has specific training in this area.

12. According to the *AMA Guides*, because the "hallmark" of CRPS is a patient's subjective complaint of pain, and because many of the associated physical signs can be the result of disuse, differentiating between CRPS and such diagnoses as somatoform pain disorder, conversion disorder or even malingering is difficult. *AMA Guides*, §16.5e at p. 496. For that reason, the *Guides* impose strict diagnostic criteria for rating permanent impairment on the basis of CRPS. Before the diagnosis can be made, the *Guides* direct that the examiner observe at least eight of eleven objective signs of the condition. *Id.* The signs may be clinical – changes in skin color, temperature or texture, for example – or radiographic, as demonstrated on bone scans or x-rays. *Id.*, Table 16-16 at p. 496.

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[1] Dr. Giering also diagnosed Claimant with arthritic pain associated with his shoulder surgery and a probable injury to the brachial plexus, the network of nerves in the shoulder region, both causally related to his August 2006 fall at work.

[2] "Signs" are objective evidence of disease perceptible to the examiner. "Symptoms" are subjective sensations of the individual. *AMA Guides*, §16.5e at p. 496.

13. Most of the objective signs that the *AMA Guides* list as indicative of CRPS are similar, if not identical, to those referenced in the IASP's diagnostic rubric. Because the *Guides* require that a greater number of them be observed before the diagnosis can be made, however, the criteria are more limiting. In addition, by requiring that only observed signs can be considered, and not reported symptoms as well, the *Guides* impose even more stringent requirements on the diagnosis.[3]

14. Dr. Lefkoe evaluated Claimant on September 10, 2008. Based on Claimant's history, the serial examinations of other medical providers and his own observations, Dr. Lefkoe confirmed Dr. Giering's CRPS diagnosis. He also determined that Claimant had reached an end medical result. Based on that finding, with the Department's approval Defendant discontinued Claimant's temporary disability benefits effective October 18, 2008.

15. As for permanency, Dr. Lefkoe followed the procedure mandated by the *AMA Guides* for determining the appropriate impairment rating in cases involving the type of CRPS from which Claimant presumably suffers. In doing so, however, Dr. Lefkoe did not first establish that Claimant satisfied the *Guides'* "eight-of-eleven" diagnostic criteria. In fact, while there is sufficient evidence in the medical records to establish that Claimant properly was diagnosed with CRPS according to the IASP's diagnostic criteria, the records appear to provide insufficient support for the diagnosis under the *AMA Guides'* rubric.

16. Dr. Lefkoe determined that Claimant had suffered a 46% whole person permanent impairment as a consequence of his work injury. Of this total, only 4% was based on range of motion considerations relating specifically to Claimant's shoulder; the remainder related to the sensory deficits and pain attributable to his CRPS condition.

17. Defendant's medical expert, Dr. Wieneke, disputed Dr. Lefkoe's methodology, and therefore his permanency rating as well. Dr. Wieneke conducted two independent medical evaluations of Claimant, first in March 2008 and then again in May 2009.

18. Dr. Wieneke acknowledged in the context of his March 2008 evaluation that Claimant had exhibited "well-documented" signs of CRPS. In his opinion, the condition was still "resolving," and therefore Claimant was not yet at end medical result. Nevertheless, because he had been asked to do so, Dr. Wieneke calculated Claimant's permanent impairment, which he determined to be 7% whole person. Of this amount, Dr. Wieneke attributed 3% to Claimant's rotator cuff repair and 4% to his sensory deficits and pain.

[3] The most recent edition of the *AMA Guides* has adopted a diagnostic rubric for CRPS that is similar to the one endorsed by the IASP. Rather than requiring eight of eleven signs of the condition before the diagnosis can be made, the sixth edition of the *Guides* mandates that the patient report at least one symptom in three of the same four categories delineated in the IASP rubric, and that the examiner observe at least one sign in two or more categories. *AMA Guides to the Evaluation of Permanent Impairment (6th ed.)*, Table 15-24 at p. 453.

19. Unlike Dr. Lefkoe, in deriving the rating attributable to sensory deficits and pain, Dr. Wieneke did not follow the procedure specifically mandated for patients who have met the "eight-of-eleven" test for diagnosing CRPS under the *AMA Guides*. Rather, he followed the procedure for rating sensory deficits and pain resulting generally from peripheral nerve disorders. This difference in methodology accounts for the wide variance between Dr. Lefkoe's 46% whole person rating and Dr. Wieneke's 7% rating.

20. When Dr. Wieneke next evaluated Claimant, in May 2009, he observed no residual signs of CRPS and determined that the condition had resolved. This time, Dr. Wieneke determined that Claimant had reached an end medical result, and calculated his permanent impairment at 3% whole person – 1% for residual limitations in Claimant's right shoulder motion, and 2% for generalized right upper extremity pain.

21. Dr. Giering disputed Dr. Wieneke's conclusion that Claimant's CRPS had resolved. He acknowledged that as a result of Claimant's own hard work and aggressive treatment, his condition is no longer severe. In Dr. Giering's opinion, however, Claimant still meets the IASP's diagnostic criteria for CRPS. Because the condition is now chronic, he expects that Claimant will continue to suffer flares for several years.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The dispute here centers on the extent of Claimant's permanent partial impairment. More specifically, at the core of this issue is whether Claimant has a ratable impairment attributable to CRPS. Dr. Lefkoe determined that he did; Dr. Wieneke determined that he did not.

3. Where expert medical opinions are conflicting, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

4. Here, I am compelled to reject Dr. Lefkoe's opinion – not because it is unpersuasive, but because under the particular circumstances of this case the statute requires it. Specifically, 21 V.S.A. §648(b) provides as follows:

> Any determination of the existence and degree of permanent partial impairment shall be made only in accordance with the whole person determinations as set out in the fifth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment.

5. Dr. Lefkoe used the appropriate mechanism mandated by the *AMA Guides* for rating impairment due to CRPS, but he failed first to satisfy the *Guides'* diagnostic criteria for the condition. In fact, I conclude from the medical evidence that it would have been impossible for him to do so. Claimant simply did not exhibit the required eight of eleven objective signs necessary for the diagnosis.

6. I do not doubt that under the IASP's diagnostic criteria Claimant properly was diagnosed with CRPS. It appears as well that Claimant would meet the diagnostic criteria mandated by the more recent 6th edition of the *AMA Guides.* Absent rule-making in consultation with the Department of Labor Advisory Council, however, §648 specifically prohibits the use of any version of the *Guides* subsequent to the 5th edition.

7. I conclude that there can be no ratable impairment for CRPS under the 5th edition of the *AMA Guides* unless the diagnosis is established in accordance with the criteria mandated therein. Vermont's workers' compensation statute requires that I reject any rating that is not derived directly from that source.[4] For that reason alone, I must discard Dr. Lefkoe's opinion.

8. I am left with Dr. Wieneke's impairment ratings. I cannot consider Dr. Wieneke's March 2008 determination, as he himself later retracted it. The only rating available for consideration, therefore, is Dr. Wieneke's May 2009 rating. That rating – 3% whole person – was calculated in accordance with the *AMA Guides* and therefore is acceptable under §648.

9. As Claimant has not prevailed on his claim for permanency benefits in accordance with Dr. Lefkoe's impairment rating, he is not entitled to an award of costs or fees.

[4] It should be noted that §648 only mandates that the *AMA Guides* be used in the context of determining the "existence and degree" of an injured worker's permanent impairment. Where the disputed issues revolve around other workers' compensation benefits, such as temporary total disability, coverage for reasonable and necessary medical treatment or vocational rehabilitation, the *Guides'* diagnostic criteria are not necessarily determinative. *See Chartier v. Central Vermont Medical Center*, Opinion No. 22-09WC (June 26, 2009).

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, Defendant is hereby **ORDERED** to pay:

1. Permanent partial disability benefits in accordance with Dr. Wieneke's 3% whole person impairment rating, commencing on October 18, 2008; with credit for any amounts already paid and with interest on any unpaid amounts in accordance with 21 V.S.A. §664.

DATED at Montpelier, Vermont this 15th day of April 2010.

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Patricia Moulton Powden
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.