The Vermont Supreme Court Nullifies the AMA Guides' Diagnostic Criteria for Rating Impairments Due to Complex Regional Pain Syndrome in Workers' Compensation Cases

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The Vermont Supreme Court's decision in *Brown v. W.T. Martin Plumbing & Heating, Inc.*, 2013 VT 38 (June 21, 2013) issued on the summer solstice but ushered in a winter of discontent for employers and workers' compensation insurers. *Brown* grapples with the meaning and scope of § 648(b) of the Workers' Compensation Act (WCA), which provides that "[a]ny 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." The Court held that the statute authorizes an award of permanent partial disability (PPD) benefits to injured workers based on the impairment rating methodology for complex regional pain syndrome (CRPS) set forth in the AMA Guides to the Evaluation of Permanent Impairment (5th ed.) *regardless* of whether their injuries or conditions satisfy the Guides' diagnostic criteria for CRPS. Because the basic structure of the Guides as applied to CRPS is crucial to understanding *Brown*'s doctrinal significance, some background is necessary.

Although the Guides generally do not predicate impairment rating methods on particular diagnoses, Chapter 16 of the Guides (the one at issue in *Brown*) expressly carves out an exception to this rule for CRPS. The syndrome is notoriously difficult to accurately diagnose, and medical scientists and clinicians are still struggling to understand its pathogenesis and pathophysiology.[i] CRPS is generally defined as a chronic neuropathic pain disorder that involves dysregulation of the central and sympathetic nervous systems and results in sensory dysfunction, inflammation, motor deficits and/or trophic abnormalities.[ii] Patients with CRPS I (the type at issue in *Brown*) typically present with complaints of continuous, debilitating limb pain that extends beyond a specific nerve distribution, is disproportionate to the inciting trauma, and cannot be traced to a demonstrable nerve lesion.[iii] The risks of misdiagnosing CRPS are appreciable because current metrics for measuring pain are completely subjective, the medical community has yet to develop a "gold standard" or objective test for diagnosing CRPS, and many signs and symptoms associated with CRPS are also indicative of other neuropathic pain syndromes, vascular diseases, and a host of psychiatric problems such as somatoform pain disorder, conversion disorder, and malingering.[iv]

Given the abstruse nature of CRPS and the lack of definitive objective tests to confirm its existence, it is not surprising that the diagnostic criteria for CRPS have been the subject of extensive debate and controversy within the medical community for decades.[v] *Brown* features two competing diagnostic criteria for CRPS—those published in 1999 by The International Association for the Study

of Pain (IASP) and those set forth in the 5th edition of the Guides. Both diagnostic rubrics require a certain number of signs and symptoms across four main categories: (1) sensory abnormalities such as hyperalgesia and allodynia, (2) vasomotor dysfunction such as skin color and temperature changes, (3) sudomotor dysfunction such as sweating and swelling, and (4) motor/trophic abnormalities such as motion deficits and abnormal nail/hair growth.[vi] The Guides' criteria, however, are more stringent than the IASP criteria.[vii] A patient need only report one symptom in each of the four categories and exhibit one sign in two of the categories in order to satisfy the IASP criteria.[viii] The Guides mandate that the examiner personally observe at least eight of eleven objective signs.[ix]

Neither diagnostic framework is calibrated to ensure an infallible diagnosis in every case. Studies reveal that the IASP criteria are adequately sensitive (*i.e.*, rarely fail to detect a case of actual CRPS) but have poor specificity (*i.e.*, result in overdiagnosis) whereas the Guides achieve a high level of specificity at the expense of sensitivity.[x] Because the impairment rating statute designates the Guides as the "only" method to be used in determining the "existence and degree of permanent partial impairment," the prevailing wisdom in the pre-*Brown* era was that any CRPS rating under Chapter 16 of the Guides was compensable only if it passed muster under the Guides' diagnostic criteria.

In *Brown*, both the DOL and superior court had concluded that the statute precluded a ratable impairment for CRPS in Brown's case because (1) the applicable sections of the Guides require that all ratings for CRPS be premised on fulfillment of the corresponding diagnostic criteria, and (2) it was undisputed that Brown's constellation of signs and symptoms did not meet the Guides' diagnostic criteria for CRPS. Notably, Brown's failure to satisfy these criteria did not preclude a recovery based on other available rating methods. In fact, both the DOL and the superior court awarded Brown PPD benefits based on impairment associated with sensory and motor deficits, and the DOL indicated that any impairment attributable to Brown's pain or sensory deficits could have been appropriately rated by utilizing the method applicable to general peripheral nerve disorders.[xi] Nonetheless, the 3% and 6% whole person impairment ratings accepted by the DOL and superior court respectively were a distant cry from the 46% rating the Guides would have yielded for a CRPS diagnosis (assuming a base compensation rate of $500.00 and excluding COLAs, a 3% rating would yield a PPD award of $6,075.00 whereas a 46% rating would yield an award of $93,150.00).

Writing for the Court in *Brown*, Justice Robinson declared that the "clear" language of the statute required use of the Guides in determining the level of impairment associated with a compensable injury, but it did *not* mandate use of the Guides' diagnostic criteria as part of the impairment rating process:

> Nowhere does the statute state that the AMA Guides provide the exclusive mechanism for determining the existence of, or diagnosis associated with, a compensable injury. Rather, the statute declares that the rating of *an impairment* is to be conducted pursuant to the AMA Guides. To the extent that Chapter 16 of the AMA Guides purports to establish fixed criteria for *diagnosing* CRPS, as opposed to a method for rating the impairment associated with that condition, [the statute] does not imbue those criteria with the force of law.[xii]

Robinson went on to conclude that the Guides' diagnostic criteria were severable from the rating methodology in CRPS cases because *other* sections of the Guides "expressly allow evaluators to rate an impairment using the rating method set forth in a specific section of the Guides even if an individual's condition (or diagnosis) is not the condition (or diagnosis) for which that section is specifically designed."[xiii]

More fundamentally, Robinson posited that a strict construction of the statute "best jibes" with the goal of maximizing benefit awards "unless the law is clear to the contrary."[xiv] It is somewhat difficult to reconcile this dimension of *Brown* with existing precedent. The Court has historically afforded "substantial deference" to the DOL given its special expertise in this area, and has stated that it will uphold the DOL's interpretation and application of the WCA "absent a compelling indication of error."[xv] While the Court's interpretation of the impairment rating statute may have been plausible on its face, it was far from "compelling" and it certainly was not the only reasonable interpretation. *Brown*, therefore, indicates that deference will be granted only where the DOL construes the WCA "liberally so that injured employees receive benefits."[xvi]

In a lone dissent, Justice Dooley lambasted the majority for exploiting an interpretive "loophole" and reducing the statute to a "paper tiger" for no reason other than a bare desire to maximize Brown's recovery.[xvii] He asserted that "the purpose of [the statute] is to bring objectivity, consistency and predictability to the impairment determination process," and that where the Guides "require a specific diagnosis as part of the process of determining an impairment rating, the statute requires that determination process to be followed."[xviii] As Dooley observed, "the Guides clearly state that there is no permanent partial impairment due to CRPS unless the condition is diagnosed under its requirements."[xix] He reasoned that the Guides—and by extension, the statute—compelled a finding against Brown as a matter of law and logic:

> For CRPS, the policy of the Guides is that there is *no* applicable impairment absent a diagnosis of CRPS pursuant to the Guides. In other words, the proper impairment rating under Chapter 16 of the Guides—the Chapter used in this case—is zero … If the 'existence' question is controlled by the Guides—as the statute says it must be—the answer is that, whatever claimant's symptoms, they are not caused by CRPS and do not show a permanent impairment of the magnitude of a CRPS impairment.[xx]

Dooley also argued that the Court's "broad dicta" (*viz.*, its pronouncement that physicians and adjudicative fact-finders may endorse rating methods set forth in specific sections of the Guides notwithstanding the fact that those sections are not even designed for the underlying condition or diagnosis) was "the equivalent of repealing § 648(b)."[xxi] In closing, he openly invited a legislative reprisal:

> The majority has found an ambiguity in the legislative drafting that it can exploit, but it has not found a reason why the Legislature would ever intend its construction of the statute, which so clearly undermines its intent. Indeed, I urge the Legislature to take a close look at § 648(b) in light of this decision. It no longer provides meaningful regulation of the impairment rating system.[xxii]

The Court in *Brown* did not cabin its opinion to CRPS impairment disputes arising in workers' compensation proceedings, and some of the more sweeping dicta may portend a general loosening in the joints of the impairment rating system for conditions other than CRPS (and in cases outside the workers' compensation context). It is difficult to predict whether *Brown*'s "broad dicta" will develop jurisprudential teeth. It is clear, however, that employers and workers' compensation insurers will experience a dramatic and systemic increase in PPD exposure under *Brown*, as injured workers can now avail themselves of the Guides' generous rating method for CRPS without having to contend with its rigorous diagnostic gatekeepers.

Even before *Brown*, the DOL in *non*-impairment cases consistently shelved the Guides in favor of the more liberal "Budapest" or "Harden" criteria for diagnosing CRPS.[xxiii] While the Budapest/Harden criteria aspire to greater objectivity than the original IASP criteria, they too rely heavily on patient-reported symptoms (as opposed to objective signs detected by the examiner) and, therefore, err on the side of overdiagnosis.[xxiv] In the wake of *Brown*, the Budapest/Harden criteria will be the yardstick by which all expert opinion testimony regarding CRPS is measured, and the DOL will regard these criteria as authoritative in resolving compensability contests along the entire spectrum of indemnity and medical benefits. As a diagnostic paradigm to be used in CRPS cases, the Guides have officially drifted into obsolescence.[xxv]

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[i] *See, e.g.*, Bruehl, S. An Update on the Pathophysiology of Complex Regional Pain Syndrome, Anesthesiology 2010; 113: 713-25; de Mos, M, Sturkenboom, MCJM, Huygen, FJPM. Current Understandings on Complex Regional Pain Syndrome, Pain Practice 2009; Vol. 9, Issue 2 at 86-99.
[ii] *See id*.
[iii] 2013 VT at ¶¶ 7, 17.
[iv] Harden, RN, Bruehl, S, Stanton-Hicks, M, Wilson, PR. Proposed New Diagnostic Criteria for Complex Regional Pain Syndrome, Pain Medicine 2007; 8:326-31; van Eijs, F, Stanton-Hicks, M, Van Zundert, J, Faber, CG, Lubenow, TR, Mekhail, N, van Kleef, M, Huygen, F. Complex Regional Pain Syndrome, Pain Practice 2011, Vol. 11, Issue 1 at 70-87.
[v] *See, e.g.*, 2013 VT at ¶¶ 39-45 (Dooley, J., dissenting)
[vi] *See Brown v. W.T. Martin Plumbing & Heating*, Opinion No. 14-10WC (April 15, 2010).
[vii] 2013 VT at ¶ 8.
[viii] *Brown*, Opinion No. 14-10WC at 2.
[ix] *Id*. at 2-3.
[x] *See, e.g.*, Harden, RN, Bruehl, S, Stanton-Hicks, M, Wilson, PR. Proposed New Diagnostic Criteria for Complex Regional Pain Syndrome, Pain Medicine 2007; 8:326-31.
[xi] 2013 VT at ¶ 11; Opinion No. 14-10WC at 3-4.
[xii] 2013 VT at ¶¶ 21-22 (emphasis in original).
[xiii] *Id.* at ¶ 32.
[xiv] *Id*. at ¶¶ 19, 25.
[xv] *See, e.g., Cyr v. McDermott's, Inc.*, 187 Vt. 392, 401 (2010); *Letourneau v. A.N. Deringer/Wausau Ins. Co*., 184 Vt. 422, 426 (2008).
[xvi] 2013 VT at ¶ 19.
[xvii] *Id.* at ¶¶ 37-38 (Dooley, J., dissenting).
[xviii] *Id.* at ¶¶ 56, 67.
[xix] *Id.* at ¶ 57.
[xx] *Id.* at ¶¶ 38, 56.
[xxi] *Id*. at ¶ 66.
[xxii] *Id*. at ¶ 68.
[xxiii] *See Westover v. North Country Hospital*, Opinion No. 19-12WC (July 20, 2012)(holding that AMA Guides' diagnostic criteria for CRPS are not determinative on issues relating to temporary disability and medical benefits and recognizing that Budapest/Harden criteria "better define the condition and refine a practitioner's ability to diagnose it"); *Jacobs v. Metz & Associates, Ltd.*, Opinion No. 02-12WC (Jan. 11, 2012)(adopting Budapest/Harden criteria as the "currently accepted diagnostic criteria for CRPS").
[xxiv] Harden, RN. Objectification of the Diagnostic Criteria for CRPS, Pain Medicine 2010; 11: 1212-15.
[xxv] This applies only to the 5th edition of the Guides. The 6th edition incorporates the Budapest/Harden criteria.