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DIVISION ONE

MAR 05 2010

Revision 3/5/2010  
**NO.643231**  
Superior Court case 08-2-42767-6 KNT

IN THE COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION I

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RONNIE G. MCELWANEY, an individual,

Appellant,

Vs.

KING COUNTY,

Respondent.

---

APPEAL FROM KING COUNTY SUPERIOR COURT  
Honorable Cheryl Carey, Judge

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BRIEF OF APPELLANTS

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Address:  
11418 71<sup>st</sup> Place South  
Seattle, WA 98178-3005

Ronnie G. McElwaney  
Pro Se

Address:  
500 4<sup>th</sup> Ave 9<sup>th</sup> Floor  
Seattle, WA 98104

Tylar Edwards  
King County Prosecutor

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DIVISION ONE  
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3:08 PM

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## **I Assignments of Error**

King County Superior Court erred by not acknowledging RCW

51.52.110 thus omitting important evidence in the board's official

records supporting appellant's case. <sup>1</sup>

RCW 51.52.110: The board shall serve upon the appealing party, the director, the self-insurer if the case involves a self-insurer, and any other party appearing at the board's proceeding, and file with the clerk of the court before trial, a certified copy of the board's official record, which shall include the notice of appeal and other pleadings, testimony and exhibits, and the board's decision and order, which shall become the record in such case.

(Rules of Practice and Procedure before the Board of Industrial Insurance Appeals of the State of Washington and Statutes Relating to the Board. p 46)

<sup>1</sup> Superior court and prosecuting attorney failed to provide any reference to the record that supports the assertion that appellant could not use official board records.

They thereby violate RCW 51.52.110

## **II Statement of the Case**

Dr. Daniel Nelson diagnosed appellant with RSD/CRPS on a more probable than not basis and as a work related injury \*(CP-official board records pg 36{Dr. Nelson's clinical notes #1}).

Dr. Daniel Nelson, a competent medical witness, testified as to the dates of onset, which were between the terminal dates \*(CP-official board records {Dr. Nelson's deposition pg 22 lines 6-9}), and that the diagnosed condition RSD/CRPS variant was caused by appellant's employment\* (CP-official board records {Dr Nelson's deposition pg 21 line 14}) and official board records pg 216 lines 10-12).

Dr. Nelson's opinion was on a more probable than not basis was affirmed on redirect \*(CP-official board records {Dr. Nelson's  
\*Appendix

deposition pg 32 lines 4-6}). The doctor is not required to utter the qualifying “on a more probable than not basis” standard. It is a measure of certainty to which the doctor could have objected to, when asked but he did not, nor did Dr. Nelson change his opinion \*(CP-official board records{Dr. Nelson’s deposition pg 32 line 6}).

### **III Argument**

L&I claim was to be reopened upon a diagnosis \*(CP-official board records pg 4 last 3 lines in par 2 of appeal). Claim has been in appeal process since King County would not reopen when diagnosis was made. Appellant has provided evidence that his condition arose during the aggravation period, and it is sufficient \*Appendix

for the medical witness (Dr. Daniel Nelson) to state that it developed between the terminal dates \*(CP-official board records {Dr. Nelson's deposition pg 22 lines 6-9}) and that the condition was caused by the fall \*(CP-official board records {Dr Nelson's deposition pg 21 line 14}) and \*(CP-official board records pg 216 lines 10-12). Docket #07 16034 is a Knowles aggravation \*(CP- official board records pg 160). \* Knowles v. Department of Labor and Indus., 28 Wn 2d 970 (1947).

Appellant symptoms fit in terminal dates (Donna R. Jones (Simmons). BIIA Dec 99 22362 (2001) and \*L&I Medical Treatment Guidelines Washington State Department of Labor and Industries (CP – official board records pgs 52-57).

\*Appendix

The burden is for appellant to present the facts that support the elements for the case, which has been done.

The opinions of the worker's treating medical practitioners are to be given special consideration by the trier of fact in Industrial Insurance cases. Loushin v. ITT Rayonier, 84 Wn. App. 113, 124-25, 924 P. 2d 953 (1996).

**V Conclusion**

Request that the decisions of the District and Superior Court be reversed and appellant be awarded L&I including pay for all time loss, medical and prescription costs dating back to

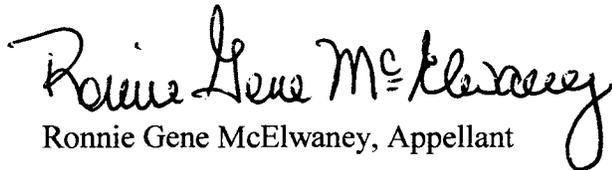
injury of 2005 plus any future time loss, medical treatments,  
and prescriptions throughout duration of anything relating to  
RSD/CRPS and depression.

Relief from any claims from L&I against appellant.

Total compensation sought 145,000 for financial hardships during 17  
months without pay to repay loans in excess of \$46,000, time  
loss, medical treatments, prescriptions, attorney and deposition fees for  
doctors and reports.

Dated: March 5, 2010

respectfully submitted,

  
Ronnie Gene McElwaney, Appellant

APPENDIX

on (date) 03/05/10

5. Service of Notice on Dependent of a Person in Military Service.

The Notice to Dependent of Person in Military Service was  served on  mailed by first class mail on (date) \_\_\_\_\_  
 Other: \_\_\_\_\_

6. Other: Certified Mail

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (city) Seattle, (state) WA on (date) 03/05/10

Ronnie Gene McElwainy  
Signature

Ronnie Gene McElwainy  
Print or Type Name

Fees:  
Service \_\_\_\_\_  
Mileage \_\_\_\_\_  
Total \_\_\_\_\_

(Tape Return Receipt here, if service was by mail.)

File the original Return of Service with the clerk. Provide a copy to the law enforcement agency where protected person resides if the documents served include a restraining order signed by the court.

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MAR 05 2010

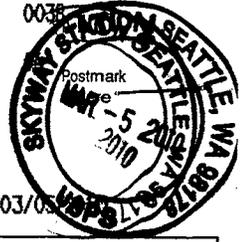
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MAR 05 2010

## Court of Appeals

## County of King

In re:

Ronnie G McElwaney

Petitioner,

and  
King County/Board of Industrials Appeals

Respondent.

No. 643231

**Proof of Service  
(Optional Use)  
(RTS)**

### ***I Declare:***

1. I am over the age of 18 years, and I am not a party to this action.
2. I served the following documents to (name) \_\_\_\_\_ King County/Board of Industrials Appeals

- summons, a copy of which is attached
- petition in this action
- proposed parenting plan or residential schedule
- proposed child support order
- proposed child support worksheets
- sealed financial source documents cover sheet and financial documents
- financial declaration
- Notice Re: Dependent of a Person in Military Service
- notice of hearing for \_\_\_\_\_
- motion for temporary order
- motion for and ex parte order
- motion for and order to show cause re: \_\_\_\_\_
- declarations of \_\_\_\_\_
- temporary order
- other: **APPELLANT TRIAL BRIEF**

3. The date, time and place of service were (if by mail refer to Paragraph 4 below):

Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Address: \_\_\_\_\_  
\_\_\_\_\_

4. Service was made pursuant to Civil Rule 4(d):

by delivery to the person named in paragraph 2 above.

McELWANEY, Ron

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**MANAGEMENT FOLLOW-UP**

DOS: 11-06-06

**INTERVAL HISTORY:** Ron is here today for follow up treatment review and planning. He is very fatigued and the pain has moved to involve both L and R side. He has concerns due to his work siltation and is under some pressure from HR. Apparently is on morphine sulfate 30 mg. b.i.d. and 15 mg. qd. Pain level today is an 8.

Part of his main complaint is his secondary sleep disorder.

**DIRECTED PHYSICAL EXAM:** In general alert and appropriate. NAD. No interval changes.

**IMPRESSION:** Complex regional pain syndrome vs. CRPS variant.

**RECOMMENDATIONS:**

1. The patient's current pain symptom complex is related to his industrial injury of spring, 2005.
2. Trial of Zanaflex qhs for sleep, 2 mg. samples given. Patient instructed to titrate up to 6 mg. over 10 days.
3. Trial of Lyrica. He doesn't believe he's been on this before. Should be tried in conjunction with the Zanaflex.
4. Various work-related issues and treatment plan reviewed. His current treatment plan would include med management, ongoing injection therapy (stellate ganglion blocks) and physical medicine/PT, as indicated. Treatment of secondary issues, such as sleep disorder, may ultimately require a referral to a sleep specialist.
5. We also discussed his problem with daytime somnolence. A trial of Provigil may be indicated in the future.



---

**DANIEL E. NELSON, M.D.**  
DEN/la

cc: Thomas H. Payne, M.D.

1 it's associated with some sort of event, some trauma.  
2 Again, sometimes a seemingly innocuous or benign event that  
3 leads to persistent pain that again is out of proportion to  
4 the initial injury.

5 I'm not aware of any marked variability as far as  
6 the actual injury to the onset of pain. Usually they're  
7 closely associated. In other words, they are -- I'm not  
8 aware of there frequently being a delay between the injury  
9 and the onset of the pain. Usually it's the persistence of  
10 the pain that becomes notable.

11 BY MR. BRYAN:

12 Q. Do you have an opinion as to whether or not his  
13 job of driving the transit bus had any relation to his  
14 regional pain syndrome?

15 A. As I recall, this was a job-related injury. I do  
16 not recall the exact details, except that there was a  
17 situation in which he was performing his job, and there was  
18 a job-related accident of some sort, or job-related injury.  
19 And the patient attributed the -- his situation, meaning his  
20 chronic extremity pain, as being related to that -- to that  
21 industrial job injury.

22 MR. BRYAN: I don't have any more questions.

23 Thanks.

24 EXAMINATION

25 BY MR. EDWARDS:

1 pain relief, they and were allowing him to do such things as  
2 activities of daily living and that sort of thing.

3 Q. Did you discuss his job?

4 A. Yes. That comes up several times in the notes.

5 Q. What was your understanding of his occupation?

6 A. I believe he was a transit bus driver, if I'm not  
7 mistaken. I'm trying to find a reference to that. That was  
8 my understanding.

9 Q. Do you have any opinions regarding the  
10 relationship to any of his previous medical traumas or  
11 cervical surgery that you mentioned as it relates to his  
12 CRPS?

13 A. The only reference is that he had the surgery in  
14 2000. And there's a job-related injury in 2005, I believe.  
15 And really nothing in-between.

16 So there's -- if one would look at this, at least  
17 on a casual basis, one would assume that the recovery from  
18 the ACDF or cervical fusion was unremarkable.

19 Q. You mentioned that small traumas can be causative  
20 for this.

21 What kind of time frame do you usually see between  
22 a trauma and the onset?

23 MR. EDWARDS: Objection. It assumes facts  
24 not in evidence.

25 A. The -- the onset is somewhat variable. Usually

1 industrial injury. If there is evidence that the new condition arose during the aggravation period,  
2 it is sufficient for the medical witness to state that it developed between the terminal dates and  
3 that the condition was proximately caused by the industrial injury. *In re: Donna R. Jones*  
4 (*Simmons*), BIIA Dec., 99 22362 (2001).

## 5 II. EVIDENCE PRESENTED

6 The claimant and his wife testified to objective findings. Claimant testified that his  
7 symptom arose out of the conditions of his particular employment as a bus driver, both in the  
8 action of steering and the unique action of loosening a difficult lever to adjust the steering wheel.  
9 Claimant also testified as to the date of onset of his new condition or disability, which was  
10 between the terminal dates, which also coincide with the treatment dates provided by the  
11 testimony of Dr. Nelson.

12 Dr. Nelson, a competent medical witness, testified as to the dates of his onset,  
13 which were between the terminal dates, and that the diagnosed condition was caused by  
14 claimant's employment. That Dr. Nelson relied on claimant's statements regarding his  
15 employment is reasonable; as this is what any doctor must do when making an opinion on  
16 causation, that is, rely on the statements of others. The fact that the details were not recorded in  
17 his notes is a matter for rebuttal, not dismissal. The same is true for Dr. Nelson's statement on  
18 causation, for he stated that the CRPS variant was caused by his work, and that his opinion was  
19 on a more probable than not basis was affirmed on redirect. The doctor is not required to utter  
20 the qualifying "on a more probable than not basis" standard. It is a measure of certainty to which  
21 the doctor could have objected to, when asked. Since he did not, his agreement with the standard  
22 is presumed.

23 In conclusion, medical witness is not required to summarize all the facts that comprise a  
24 prima facie on a more probable than not basis. The burden is for the claimant to present the facts  
25 that support the elements of the case, which the claimant has done. Therefore, claimant requests  
26 a denial of the employer's motion to dismiss.

DATED this 2nd day of September, 2008.

  
Paul W. Bryan  
Attorney for the Claimant

CLAIMANT'S RESPONSE TO  
MOTION TO DISMISS  
Page 2 of 2

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LAW OFFICE OF PAUL W. BRYAN, PLLC  
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THE BOARD OF INDUSTRIAL INSURANCE APPEALS  
SEATTLE, WA 98104-2848

1           Q.    But as your testimony that you gave regarding his  
2 work and the causation of the complex regional pain  
3 syndrome, the question is:

4                    Has your opinion changed based on the questions  
5 and information provided by Counsel?

6           A.    My opinion really is unchanged.  A patient  
7 attributes his current -- the current pain situation as I  
8 saw him initially on August 3rd, 2006 to -- as a job-related  
9 injury.

10                   The patient had those beliefs at that time.  He  
11 attached a great deal of significance to that, as far as I  
12 can recall.  Again, I was not involved in any kind of  
13 forensic activity as to the true nature or the origin of his  
14 pain.

15                   He attached significance to the job-related  
16 injury, and that was satisfactory enough for me to proceed  
17 with my treatment plan.

18                   MR. BRYAN:  Nothing further.  Thank you.

19                   (The deposition of Daniel Nelson, MD was  
20 concluded at 6:30 p.m.)

21                   (Signature was waived.)

22

23

24

25

Ronnie G. McElwaney  
Claim No. SB-55208 SA-35109  
Docket No: 06 27309 07 16034

me to stay with medical work up my primary had recommended which in part was to see a rheumatologist to figure out what the cause of pain was. Section 4 in yellow reference book

\*Laura found light duty work for me, but I was struggling with a sleep disorder which is an effect of CRPS. So Dr Payne Wrote note excusing me from light duty for about 6 weeks until I was able to get an appointment with other Dr's. This apparently made Laura Merritt angry because she verbally said during a phone call to me which my wife also heard that she was determined to blame this L&I on a previous L&I (neck claim from 1996) and sent Dr. Hall 175 pages of additional, past medical history to which he made an addendum agreeing with her even though I have gone through all the chart notes he used, at times he even uses pain on left side that was related to kidney stones for his final report-section 6 yellow reference book(can provide actual copies of chart notes). The pain I have now is very different from the neck. I appealed this decision because CRPS/RSD would not take this long to appear (from injury in 1996 or surgery in 2000). Laura immediately closed my claim knowing I had more appointments coming up (including appointments set up by her) and she said that's fine, if you ever get your diagnosis you can always have my decision reversed and your claim reopened. I have been trying to do this ever since she closed it even after I got a diagnosis.

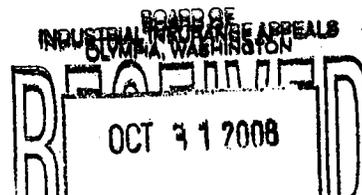
It is hard to understand the denial based on the additional chart notes when Dr. Hall originally told me and wrote in his chart notes that I needed further medical treatment. And his addendum is based on chart notes that have nothing to do with this claim. Again I have had no other accident on injury that would have caused CRPS except the fall off the bus.

After realizing a rheumatologist is not a specialist in CRPS the RDS foundation in Connecticut referred me to Dr. Nelson.

\*I met and started treatment with Dr. Nelson whom is a specialist in CRPS/RSD in August 2006 and I was diagnosed in November 2006 by Dr. Nelson who was voted one of the top Dr's in his field in Washington State in 2004 and awarded top anesthesiologist in America in 2006 – Dr Nelson gave me a definite diagnosis, not a more probable than not basis but a definite diagnosis that CRPS came from the fall off the bus in 2005-section 10 yellow reference book. I had various symptoms which included 4 of the symptoms within the L&I guidelines.

I have had 14 injections to date which has been my only relief from the pain. Injections have been every 2 ½ to 3 months since April 2007 and more frequently before that. With this diagnosis both Dr Payne and Dr. Nelson signed to have my first claim reopened SA-35109 since CRPS linked back to the fall.

\* My first mediation was with Judge Lucy Werner in January 2007 and she heard my story and saw my diagnosis and made the decision that King County had a month to





STATE OF WASHINGTON

BOARD OF INDUSTRIAL INSURANCE APPEALS

2430 Chandler Ct SW PO Box 42401 • Olympia, WA 98504-2401 • (360) 753-6823 • [www.biaa.wa.gov](http://www.biaa.wa.gov)

September 7, 2007

John Scannell  
ActionLaw.net  
PO Box 3254  
Seattle WA 98114

In re: Ronnie G. McElwaney  
Docket Nos.: 07 16034 & 06 27309  
Claim Nos.: SB-55208 & SA-35109

Dear Mr. Scannell:

Please find enclosed a paper I did on aggravation in worker's compensation. If the jurisdictional history is stipulated into the record, I believe that Mr. McElwaney's appeal in Docket No. 07 16034 is a *Knowles* aggravation. The focus in that type of appeal is whether the claimant developed a new condition, after T1, proximately related to the industrial injury, such that he needed further treatment or had increased ppd.

This letter is also to confirm that at the conference held on September 6, 2007, I determined that the most efficient way to pursue both of these appeals is to consolidate them for hearing purposes. Judge Molchior will have to decide which hearing times will remain on her docket. I am retaining the appeals for two weeks to give you time to determine whether you and the employer can reach a stipulation as to the jurisdictional facts in Docket No. 07 16034, which will determine the exact issue before the Board in that docket.

I will notify Judge Molchior of what transpired at the conference held on September 6, 2007. I look forward to hearing from you in the near future.

Yours truly,



Sally R. Sawtell  
Mediation Judge

c: Jane Downey

Enclosure

AGGRAVATION; TERMINAL DATES; PROOF  
By Sally Sawtell

As originally enacted in 1911, the Industrial Insurance Act provided for the reopening of claims in the event of "aggravation of disability". Laws of 1911, ch.74. Over the years, because of numerous appellate court decisions, and the permutations of the statute, the term "aggravation" has become complex and convoluted, such that even experienced practitioners in workers compensation can become confused about what proof needs to be presented to the Department or the Board when seeking to reopen a claim.

The statutory right to apply to reopen an industrial insurance claim is contained in RCW 51.28.040, which states that:

If change of circumstances warrants an increase or rearrangement of compensation, like application shall be made therefore. Where the application has been granted, compensation and other benefits if in order shall be allowed for periods of time up to sixty days prior to the receipt of such application.

Thus, if an injured worker's medical condition related to the industrial injury or occupational disease "changes", the worker may apply to have the claim reopened for further benefits which could include treatment, time loss compensation, permanent partial disability award, or placement on the pension rolls.

The statute governing the rules for filing applications to reopen claims for aggravation of condition, definitions, and time limits, is RCW 51.32.160, which provides as follows:

- (1)(a) **If aggravation, diminution, or termination of disability takes place, the director may, upon the application of the beneficiary, made within seven years from the date the first closing order becomes final, or at any time upon his or her own motion, readjust the rate of compensation in accordance with the rules in this section provided for the same, or in a proper case terminate the**

payment: PROVIDED, that the director may, upon application of the worker made at any time, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. The department shall promptly mail a copy of the application to the employer at the employer's last known address as shown by the records of the department.

- (b) "Closing order" as used in this section means an order based on factors which include medical recommendation, advice, or examination.
  - (c) Applications for benefits where the claim has been closed without medication recommendation, advice, or examination are not subject to the seven year limitation of this section. The preceding sentence shall not apply to any closing order issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall, for the purposes of this section only, be deemed issued on July 1, 1985. The time limitations of this section shall be ten years in claims involving loss of vision or function of the eyes.
  - (d) If an order denying an application to reopen filed on or after July 1, 1998, is not issued within ninety days of receipt of such application by the self-insured employer or the department, such application shall be deemed granted. However, for good cause, the department may extend the time for making the final determination on the application for an additional sixty days.
- (2) If a worker receiving a pension for total disability returns to gainful employment for wages, the director may suspend or terminate the rate of compensation established for the disability without producing medical evidence that shows that a diminution of the disability has occurred.
  - (3) No act done or ordered to be done by the director, or the department prior to the signing and filing in the matter of a written order for such readjustment shall be grounds for such readjustment. (Emphasis added).

When seeking to reopen a claim, the issue of "aggravation of disability" is

---

The opinions expressed in these materials are those of the author and do not necessarily represent the opinions or conclusions of the Board of Industrial Insurance Appeals.

raised, and two distinct time periods must be identified. The first time period is the period during which an application to reopen can be filed, which entitles the worker to make claim to future disability benefits. The second is the time period within which aggravation of the condition must be established, as defined by the first and second terminal dates. The events that define these two distinct time periods are different, thus making the statute of limitations date different from the dates that define the proof of aggravation time period.

### **TIME PERIOD FOR FILING AGGRAVATION APPLICATIONS**

The aggravation statute allows for one seven year period (ten years in claims involving loss of vision or function of the eye) within which the injured worker can seek to file reopening applications and be eligible for receipt of all benefits. This seven year period does not limit the worker from seeking to reopen the claim for treatment only. Alternatively, the Director at any time on his or her own motion, can waive the time limits and reopen the claim, but there must still be evidence of aggravation.

A closing order is defined in the statute as an order that is based on medical recommendation, advice or examination. The Department's administrative regulation, at WAC 296-14-400, explains this phrase further by stating that:

In order to support a final claim closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner. The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

Neither the statute nor the regulation addresses the adequacy of the medical recommendation contained in the claim file. Seemingly, the claim file must contain some medical documentation on or about the date of the closing order

in order for the definition of claim closure to be met and the statute of limitations to begin running.

The seven year period begins to run on "the date the first closing order becomes final". This specific reference in the statute emphasizes that the period does not commence until the period to file a notice of appeal has expired (i.e. sixty days from communication of the order or if an appeal has been filed, a final determination is made). See Hunter v. Department of Labor and Indus., 190 Wash. 380 (1937) and In re Daniel Bauer, BIIA Dec., 47,841 (1977). The date of the last installment payment made on any permanent partial disability award does not begin the tolling because it is not the date of the final **determinative** order. Hunter, supra.

Identification of the first claim closure based upon medical advice is usually not a problem when the closure included a permanent partial disability award. These closures are usually based upon a panel exam or the recommendation of a worker's doctor. More difficult can be the self-insured or Department order closing the claim with medical only. Always look to assure that there is medical documentation in the file at or around the date of the order first closing a claim if you are seeking to show that the statute of limitation did not begin to run.

### **TERMINAL DATES**

That section of RCW 51.32.160 that imposes time limits on the filing of an aggravation application should not be confused with identifying the required proof in any aggravation case. The time period in which aggravation must be established is defined by "terminal dates", commonly referred to as "T-1" and "T-2". It is between these terminal dates that aggravation must have occurred in order to establish further benefits under the Act. In cases before the Board, typically there are few problems in the identification of the T-2 date because it is always the date of the Department order under appeal, or the date that the Department issued an order reopening the claim (in an

employer appeal from a reopening order). It is the T-1 date that sometimes gets tricky and confusing.

The first terminal date is the last final order that previously closed the claim or denied a prior aggravation application on its merits. Kleven v. Dept. of Labor & Indus., 40 Wn.2d 415 (1952); Karniss v. Dept. of Labor & Indus., 39 Wn.2d 898 (1952). The principle of *res judicata* is at the heart of understanding aggravation issues because the closing order becomes final as to the injured worker's disability on the date the order was issued, but not as to any disability which developed subsequently. Kleven and Karniss supra. The T-1 closing order also serves to segregate or deny responsibility for any conditions which are specifically described and segregated; however, it cannot serve as the basis of segregation by implication. King v. Dept. of Labor & Indus., 12 Wn.App. 1 (1974); In re Lyssa Smith, BIIA Dec. 86 1152 (1988)

If the order that determines the first terminal date has been appealed, there can be no determination of aggravation until such appeal has been resolved and the order becomes a final determination. Reid v. Dep't of Labor & Indus., 1 Wn. 2d 430 (1939).

One area that frequently trips up representatives in identifying T-1 is in cases that have had appeals from a closing order that resulted in some kind of agreement, Board order or Superior Court order. In response to the Board or Superior Court order, the Department has issued a ministerial order. T-1 is never the date of the ministerial order, or the date of the Board order or the Superior Court order. That is because Board and Superior Court orders relate to the date of the Department's closure order, determining what the worker's condition was at the time of claim closure. Karniss; In re Jimmy Storer, BIIA Dec.86 4436 (1988); In re Donald Workman, BIIA Dec. 00 24102 (2001).

### **BURDEN OF PROOF**

The Court in Phillips v. Department of Labor & Indus., 49 Wn.2d 195 (1956) is often cited because it quite succinctly compiled the elements of

proof in an aggravation case. To establish entitlement to benefits for aggravation of the condition:

- (1) The **causal relationship** between the injury and the subsequent disability must be **established by medical testimony**. Cyr v. Dept. of Labor & Indus., 47 Wn.2d 92 (1955);
- (2) The claimant must prove by **medical testimony**, some of it based upon **objective** symptoms, that an aggravation of the injury resulted in increased disability. Moses v. Dept. of Labor & Indus., 44 Wn.2d 511 (1954) p. 517;
- (3) A claimant's **medical testimony** must show that the **increased aggravation occurred between the terminal dates** of the aggravation period. Moses v. Dept. of Labor & Indus., 44 Wn.2d 511 (1954); and
- (4) A claimant must prove by medical testimony, some of it based upon objective symptoms which existed on or prior to the closing date, that **the disability on the date of the closing order was greater than the Department found it to be**. Hyde v. Dept. of Labor & Indus., 46 Wn.2d 31 (1955).

To show aggravation, you do not have to prove an increase in a category of impairment, but you still must show an increase in loss of bodily function demonstrated by objective findings. In re Jean Wassmann, BIIA Dec., 69 953 (1986). A worker's subjective complaint of increased pain is insufficient to show worsening since there must be some objective findings to support the complaints of increased pain and loss of function. In re John Anderson, BIIA Dec. 91 6315 (1992). An increase in one finding does not necessarily mean an increase in disability or an increase in loss of function. Naillon v. Dept. of Labor & Indus., 65 Wn.2d 544 (1965).

In proving aggravation, the worker has the burden of establishing these elements by a preponderance of the evidence. In an employer appeal questioning the Department action of reopening a claim, the employer has the initial burden of going forward first with evidence. *See* RCW 51.52.050 and Olympia Brewing Co. v. Dept. of Labor & Indus., 34 Wn.2d 498 (1949). If the employer establishes a *prima facie* case, however, the burden shifts to the worker and the Department to establish entitlement to benefits by a preponderance of the evidence.

## TYPES OF AGGRAVATION CASES

A number of past aggravation cases have had far-reaching effect upon modifying the elements of proof in an aggravation case as set forth in Phillips. They are commonly referred to by the name of the worker in the case. These types of aggravation cases serve to relieve the worker from establishing some or all of the necessary elements for showing aggravation of condition.

Once the practitioner has identified the proper terminal dates, and identified the relief sought, consideration of what **type** of aggravation case will shape the decision about what evidence will need to be presented. If the case is on appeal before the Board, use the mediation conference to discuss and clarify the type of aggravation case that you have to be sure that everyone is on the same page as to what proof will be needed, whether you resolve the appeal by an agreement or proceed to hearing.

In a **Picich/Collins** aggravation case, the worker is relieved from the burden of establishing aggravation of condition by the Department's having reopened the claim and paid an additional permanent partial disability award. Picich v. Dept. of Labor & Indus., 59 Wn.2d 467 (1962); Collins v. Dept. of Labor & Indus., 50 Wn.2d 194 (1957). The issue raised in a **Picich/Collins** aggravation case is the extent of the claimant's disability on the second terminal date. It is frequently treated as if it were a direct appeal from the second terminal date order (unless it is an appeal by the employer, in which case the proof would be analyzed as an ordinary aggravation case if the employer makes a *prima facie* case).

By contrast to the **Picich/Collins** aggravation case is the **Dinnis** aggravation. Analysis of the type of proof required in this type of aggravation case is frequently misunderstood. A **Dinnis** aggravation case involves a claim that the Department has reopened, provided further treatment, maybe time loss compensation, and then closed **without** additional permanent partial disability award. Dinnis v. Dept of Labor & Indus., 67 Wn.2d 654 (1965). In this type of aggravation case, the type of relief you are seeking will determine whether the claimant must establish all of the elements of worsening. For

although the Department has conceded a temporary aggravation by reopening the claim for further treatment, the claimant is still under the burden of establishing worsening of condition resulting in increased permanent disability in order to obtain an increased disability award. In re Leon Wheeler, BIIA Dec. 70 344 (1986); In re John Qualls, BIIA Dec. 28 430 (1969). Where the Department has admitted a temporary worsening by reopening a claim, the claimant does not have to show comparative evidence of worsening if seeking to keep the claim open for treatment and time loss compensation. In re Maria Chavez, BIIA Dec. 87 0640 (1988). Boiled down, in a **Dinnis** aggravation, the claimant must show aggravation if increased permanent disability is sought. Proof of aggravation is **not** necessary if continued treatment and time loss compensation are sought.

The **Jessie White** aggravation case involves a claim that was closed without award for permanent partial disability at the first terminal date. This type of claim closure is *res judicata* that as of that T-1 date, the claimant had no disability that was causally related to the industrial injury. White v Dept of Labor & Indus., 48 Wn.2d 413 (1956). Practitioners often cite this case for the proposition that worsening or aggravation can be established at the second terminal date without the necessity of providing a medical comparison of objective findings, and by simply establishing disability causally related to the industrial injury which exists on the second terminal date. Maybe, but the Board does not interpret White to eliminate the requirement that worsening be shown by comparative medical testimony.

The rule in White that permits the assumption that there was no disability at T-1 attributable to the injury/occupational disease if the claim was closed without permanent disability, is not applicable where the causal relationship of the condition to the occupational disease or industrial injury is at issue. In re Mary Burbank, BIIA Dec. 30 673 (1969). The T-1 closure without permanent disability award only establishes that on that date there was no disability attributable to the occupational exposure or injury. Thus, if the medical evidence establishes that there was permanent disability on the first

terminal date, the Department's failure to compensate the worker constitutes a determination that the disability existing at that time was not caused by the industrial injury. In re Leona McCleneghan, BIIA Dec. 24 922 (1967).

Would the worker who shows that she did have permanent partial disability proximately caused by the industrial injury as of T-1, but did not receive an award, be able to receive the award at T-2? Probably not, but if there is no specific segregation of a pre-existing disability on T-1, the worker would not be prevented from establishing causal relationship in an aggravation appeal and using increased findings to prove aggravation and need for treatment.

White does not operate to provide implied segregation of any condition existing as of T-1. The worker may still establish causal relationship between the industrial injury and conditions which develop either before or after the first terminal date by establishing worsening of those conditions between the terminal dates. However, the claimant can't rely on disability existing as of T-1 to establish aggravation, as that disability has been determined not to be compensable.

White sets a minimum level of proof for a *prima facie* case in aggravation cases closed without permanent disability award at T-1. The case really only addresses the sufficiency of evidence necessary to withstand a judgment notwithstanding the verdict and does not purport to set the standard for how the practitioner would present such a case. Bottom line: Even in a **Jessie White** aggravation case, ask your medical witness to explain if there are objective findings of worsening of the condition related to the industrial injury between the terminal dates, assuming no findings of disability at T-1.

A **Knowles** aggravation case involves a condition which develops after the first terminal date, as a proximate result of the condition originally accepted under the claim. Knowles v. Department of Labor & Indus., 28 Wn.2d 970 (1947). This type of appeal involves establishing the causal relationship between the condition caused by the injury/ occupational disease and showing that the condition developed between the terminal dates. It is somewhat like White in that worsening is not necessarily shown by establishing that the

worker had developed a new condition as of T-2 that had not been acknowledged with a permanent partial disability award at T-1. The worker must show through medical testimony that the new condition affecting disability is traceable to the original injury claim and developed between the terminal dates.

A **McDougle** aggravation involves a situation where a new event or activity has aggravated a condition causally related to the industrial injury/occupational disease. The question is whether the new event or activity constitutes a new injury or a subsequent intervening cause and the aggravation of a condition caused by a prior industrial injury. Most of these types of cases arise where the claimant has had an off-the-job event occur that has affected the condition causally related to the industrial insurance claim. The McDougle Court held that the aggravation of the claimant's condition caused by the ordinary incidents of living - by work which he could be expected to do; by sports or activities in which he could be expected to participate - is compensable because it is attributable to the condition caused by the original injury. McDougle v. Department of Labor & Indus., 64 Wn.2d 640 (1964). The question then becomes whether the claimant was acting reasonably in light of his industrially related condition when he engaged in the off-the-job activity. Scott Paper Co. v. Dept. of Labor and Indus., 73 Wn.2d 840 (1968).

However, when a new traumatic event, identifiable in time and place, results in the aggravation of the condition caused by the industrial injury, the Board on numerous occasion has held that the aggravation was due to a new and intervening, independent cause and that the McDougle reasoning does not apply. See In re Leonard Roberson, BIIA Dec. 89 0106 (1990); In re Robert Tracy, BIIA Dec. 88 1695 (1990); In re William Dowd, BIIA Dec., 61 310 (1983); In re Alfred Swindell, BIIA Dec. 53 792 (1981); and In re Marian Roberts, BIIA Dec. 17 096 (1963).

Certainly if the new event occurred at work, the worker should file both an application to reopen and a new injury/occupational disease claim. The

Department should then consider both and issue a determinative order as to whether the condition is the result of a new injury or an aggravation of a prior injury, or neither. The Board has held that a new injury and an aggravation of an old injury are not mutually exclusive. See Tracy; Roberson; and In re Mary Wardlaw, BIIA Dec. 88 2105 (1990).

Issues concerning whether the claim should be an aggravation or a new industrial injury are increasingly seen before the Board, especially in cases where the Department is attempting to determine which employers are liable. In aggravation cases, there is always the question as to whether the increased disability was proximately caused by the original injury or whether it was caused by a progression of a degenerative process, or whether it was caused by other events that happen in a person's life, outside of work. The test is found in Simpson Logging Co. v. Dept of Labor and Indus., 32 Wn.2d 472 (1949) which states that "the cause must be proximate in the sense that there existed no intervening independent and sufficient cause for the disease, so that the disease would not have been contracted **but for** the condition existing in the extrahazardous employment." The Board has oft cited to the proximate cause language and looked at whether the new event could be considered an injury under the Act, and if it could, then the new event was treated as a new injury and aggravation denied. Whether the new event should be considered a new injury or new occupational disease, or a supervening injury under the Act has continually presented problems to the Board and the Courts as to what factors to look at. Most frequently, the Board looks at the medical testimony, letting the physicians try and medically state whether the condition is proximately caused by the old injury/occupational disease or the new injury/occupational disease. In re Robert Tracy; In re Leonard Roberson, *ibid.* But generally doctors are not able to state realistically with any degree of medical certainty whether the condition is from a prior injury or occupational disease, or a new supervening one, and most do not particularly care, since doctors are primarily concerned with treatment and not liability issues.

In situations with two different claims and two different employers, sometimes the Department has jurisdiction only over one claim and one employer, making it pretty much impossible to adjudicate which employer should be on the risk. Sometimes the self-insured section of the Department has jurisdiction over one, and the state fund section has jurisdiction over the other. In these situations, WAC 296-14-420 comes into play, obligating the Department to issue a joint order determining whether benefits should be paid pursuant to a reopening application (aggravation) or allowed as a new claim.

The courts recently had an opportunity to shine some light in the interplay between been aggravation and new injury. However, the Supreme Court ended up ducking aggravation versus new injury issue, and only addressed whether the last injurious exposure rule was applicable to industrial injury cases or limited to occupational disease cases. Cowlitz Stud Company v. Dana Clevenger and the Dept of Labor and Indus., 127 Wn. App. 542 (2005). In this matter, Ms. Clevenger worked for Cowlitz Stud from 1995 through 1999, hurting her low back in a May 1997 industrial injury. This claim was closed in July 1997 with medical benefits only. Ms. Clevenger began treating with a doctor a month prior to the claim closure, who diagnosed pre-existing degenerative disc disease at L5-S1. Then in November 1999, the mill changed owners and became Hampton Mill, and Ms. Clevenger continued in her job. From November 1999 through May 2000, Ms. Clevenger had pain and sensory changes down both legs. In July 2000, she applied to reopen the claim, and on December 20, 2000, the Department issued an order reopening the claim effective May 30, 2000. No one appealed the reopening order.

On January 8, 2001, the Department issued another order directing Cowlitz Stud to pay claimant intermittent time loss between July 5, 2000 and August 14, 2000. No one appealed this order. On April 5, 2001, the Department issued an order directing Cowlitz to pay time loss for the period of January 16, 2001 through April 4, 2001. Cowlitz asked Ms. Clevenger, at some point, to file a new claim for benefits, against Hampton Mill. She refused and did not file a new claim. Cowlitz appealed from the April 5, 2001

Department time loss order. After hearing, the Board adopted a proposed decision and order that affirmed the Department order. On appeal to superior court, Cowlitz brought a summary judgment motion, and the court granted it by applying the last injurious exposure rule and determining that reasonable minds could not disagree that Ms. Clevenger's employment at Hampton proximately caused her back condition to worsen.

The Court of Appeals concluded that the last injurious exposure rule dealing with apportionment, adopted in Weyerhaeuser Co v. Tri, 117 Wn.2d 128 (1991), does not just apply to occupational disease claims. The Court allowed application of the rule in Ms. Clevenger's situation, and determined that the record did not support an argument that "the condition that formed the basis for reopening her claim was the same condition on which the later award of disability benefits was predicated." Clevenger, at 546.

The Washington Supreme Court in August 2006 decided that the record was insufficient to decide whether the Department order under appeal directing Cowlitz Stud to pay time loss did not also include an evaluation of the last injurious exposure rule. Nothing is contained in the record to show the basis for the Department's order. In a footnote, the Supremes stated that because Clevenger had not shown in the hearing record what the Department's basis for the decision was, they could not respond to the issue preclusion argument (that because Cowlitz Stud had not appealed from the reopening order, they were precluded from challenging the subsequent order directing payment of time loss.)

The Supreme Court limited its decision to whether the last injurious exposure rule can be extended to industrial injuries, concluding that the rule is only applicable in occupational disease cases with successive employers, focusing on the specific language in *Tri*. The last injurious exposure rule evolved to relieve injured workers from having to show through lengthy litigations against several insurers, which of them might have contributed to the worker's occupational disease and to what extent each insurer might be liable.

The Price type of aggravation is only applicable to cases in which the worker is claiming that a psychiatric condition has either developed or worsened between the terminal dates. Price v. Dept. of Labor & Indus., 101 Wn.2d 520 (1984). The Court held that it is improper to instruct a jury on the objective-subjective distinction in cases involving psychiatric disability. Thus, the proof requirement that exists in other types of aggravation cases, that is, **objective** medical evidence of worsening, has been eliminated for cases involving psychiatric disability. There must still be medical evidence of worsening.

#### **DEEMED GRANTED**

I have not included a discussion on the "deemed granted" aspect of RCW 51.32.160 because the Department has corrected, for the most part, the habit of sitting on applications to reopen claims until the claim gets covered in moss. In 1988, when the habit was rampant, the statute was changed such that if the Department failed to act on a reopening application within certain timelines, the application was deemed granted. After the new provisions were passed, the Board issued several significant decisions, interpreting how to calculate the time lines, and what "deemed granted" means. However, these types of cases are more and more rare.

#### **CONCLUSION**

Aggravation can seem pretty mechanical, boring, and perplexing, especially when asking the aggravation questions of your physicians, who have no clue as to the relevance of the dates you are asking about. With the early identification of the necessary dates and the issues raised, however, the practitioner can avoid most of the pitfalls associated with presenting an aggravation case before the Board.

# Medical Treatment Guidelines

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Washington State Department of Labor and Industries

## Complex regional pain syndrome (CRPS)

Formerly known as reflex sympathetic dystrophy

### 1. Introduction

This bulletin outlines the Department of Labor and Industries' guidelines for diagnosing and treating Complex Regional Pain Syndrome (CRPS) – formerly known as Reflex Sympathetic Dystrophy (RSD). This guideline was developed through collaboration between the Washington State Medical Association (WSMA) Industrial Insurance/Rehabilitation Committee and the Office of the Medical Director of the Department of Labor and Industries. The protocol for CRPS physical therapy/occupational therapy (see Table 2) was developed in collaboration with the Washington State Physical Therapy and Occupational Therapy Associations.

### 2. What is complex regional pain syndrome?

Complex Regional Pain Syndromes are painful conditions that usually affect the distal part of an upper or lower extremity and are associated with characteristic clinical phenomena as described in [Table 1](#). There are two subtypes – CRPS Type I and CRPS Type II.

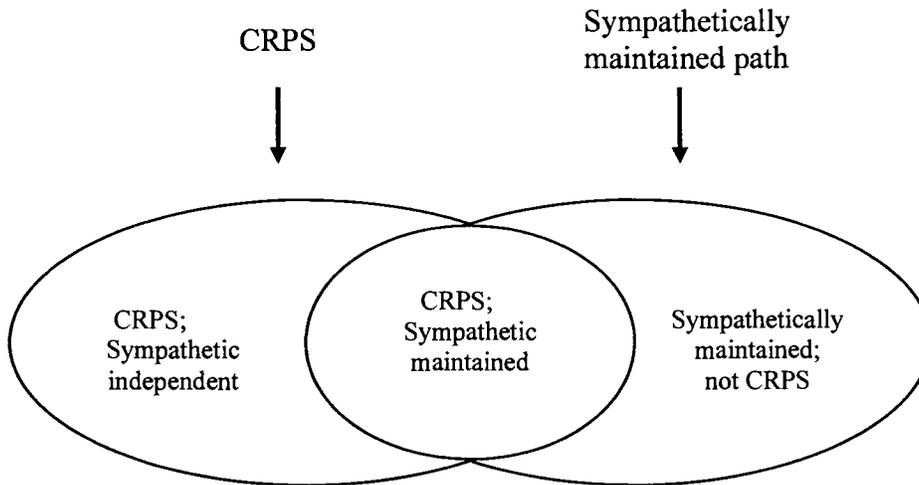
The term “Complex Regional Pain Syndrome” was introduced to replace the terms “reflex sympathetic dystrophy.” CRPS Type I used to be called reflex sympathetic dystrophy. CRPS Type II used to be called causalgia. The terminology was changed because the pathophysiology of CRPS is not known with certainty. It was determined that a descriptive term such as CRPS was preferable to “reflex sympathetic dystrophy” which carries with it the assumption that the sympathetic nervous system is important in the pathophysiology of the painful condition.

***The terms CRPS Type I and CRPS Type II are meant as descriptors of certain chronic pain syndromes. They do not embody any assumptions about pathophysiology. For the most part the clinical phenomena characteristics of CRPS Type I are the same as seen in CRPS Type II. The central difference between Type I and Type II is that, by definition, Type II occurs following a known peripheral nerve injury, whereas Type I occurs in the absence of any known nerve injury.***

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Pain that can be abolished or greatly reduced by sympathetic blockade (for example, a stellate ganglion block) is called sympathetically maintained pain. Pain that is not affected by sympathetic blockade is called sympathetically independent pain. The pain in some CRPS patients is sympathetically maintained; in others, the pain is sympathetically independent. The relation between CRPS and sympathetically maintained pain can be seen in the following Venn diagram:



\*\*\*\*\*Physicians please note\*\*\*\*\*

If you believe the CRPS condition is related to an accepted occupational injury, please provide written documentation of the relationship (on a more probable than not basis) to the original condition. Treatment for CRPS will only be authorized if the relationship to an accepted injury is established.

### 3. Diagnostic codes

After treatment authorization has been obtained from the claim manager, physicians should use billing codes that are designated for reflex sympathetic dystrophy in the International Classification of Diseases (ICD-9CM) to bill. The relevant code numbers are described below:

ICD 9-CM code	English description
337.20	Reflex sympathetic dystrophy, unspecified.
337.21	Reflex sympathetic dystrophy of the upper limb.
337.22	Reflex sympathetic dystrophy of the lower limb.
337.29	Reflex sympathetic dystrophy of other specified site.

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### 4. Key issues in making a diagnosis

- A. CRPS is a syndrome** – See whether your patient’s symptoms and signs match those described in [Table 1](#).
- B. CRPS is uncommon** - Most patients with widespread pain in an extremity do **NOT** have CRPS. **Avoid the mistake of diagnosing CRPS primarily because a patient has widespread extremity pain that does not fit an obvious anatomic pattern.** In many instances, there is no diagnostic label that adequately describes the patient’s clinical findings. It is often more appropriate to describe a patient as having “regional pain of undetermined origin” than to diagnose CRPS.
- C. Is CRPS a disease?** – Many clinicians believe that CRPS can best be construed as a “reaction pattern” to injury or to excessive activity restrictions (including immobilization) following injury. From this perspective, CRPS may be a complication of an injury or be iatrogenically induced but it is not an independent disease process.
- D. Type I CRPS vs. Type II CRPS** – In a patient with clinical findings of CRPS, the distinction between Type I and Type II CRPS depends on the physician’s assessment of the nature of the injury underlying the CRPS. In many situations, the distinction is obvious – if CRPS onsets following an ankle sprain or a fracture of the hand, it is Type I CRPS. If CRPS onsets following a gunshot wound that severely injures the median nerve, it is Type II CRPS. In ambiguous situations (for example CRPS in the context of a possible lumbar radiculopathy), the physician should be conservative in diagnosing Type II CRPS. This diagnosis should be made only when there is a known nerve injury with definable loss of sensory and/or motor function.

### 5. Typical clinical findings

A diagnostic algorithm that details the following clinical findings is located in [Table I](#) at the end of this guideline.

#### A. History

1. Symptoms develop following injury (usually symptoms begin within 2 months post injury).
2. Onset is in a single extremity.
3. Burning pain.
4. Hyperalgesia or allodynia (allodynia means pain elicited by stimuli that normally are not painful, i.e., a patient reports severe pain in response to gentle stroking of the skin.).
5. Swelling.
6. Asymmetry or instability of temperature or color.
7. Asymmetry or instability of sweating.
8. Trophic changes of skin, nails, hair.

#### B. Findings by examination

1. Hyperalgesia or allodynia.
2. Edema (if unilateral and other causes excluded). *Swelling*
3. Vasomotor changes such as asymmetry or instability of temperature/color.
4. Sudomotor changes such as excess perspiration in affected extremity. *Sweating*

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5. Trophic changes such as shiny skin, hair loss, abnormal nail growth.
6. Findings suggestive of impaired motor function such as:
  - (a) tremor.
  - (b) abnormal limb positioning.
  - (c) diffuse weakness that cannot be explained by neuralgic loss or by dysfunction of joints, ligaments, tendons or muscles.

### **C. Diagnostic test results**

A three-phase bone scan with characteristic pattern of abnormality. (NOTE – An abnormal bone scan is **not** required for the diagnosis of CRPS.)

### **D. Lack of reasonable alternative**

No other anatomic, physiologic or psychological condition that would reasonably account for the patient's pain and dysfunction.

## **6. Sympathetic blockade in the diagnosis of CRPS**

- A.** CRPS is considered a clinical syndrome, based on the criteria previously described in typical clinical findings and detailed in Table 1.
- B.** A patient's response to a diagnostic sympathetic block provides information about whether his/her pain is sympathetically maintained, but neither establishes nor refutes a diagnosis of CRPS. Therefore, a sympathetic block is not considered to be a definitive diagnostic test for CRPS.
- C.** In the patient with CRPS the purpose of a sympathetic block is to guide treatment. If a CRPS patient responds positively to a sympathetic block (indicating that his/her pain is sympathetically maintained) repeat blocks might be useful in the overall treatment plan.
- D.** If a patient does NOT meet the criteria for diagnosing CRPS as given in Table I, but the attending physician feels that the patient has sympathetically maintained pain, you may request authorization for a diagnostic sympathetic block. Requests to the state fund for a diagnostic sympathetic block should be sent to the L&I Office of the Medical Director for review.

## **7. An overview of treatment**

***Experts in CRPS believe the probability of a patient developing this condition can be reduced by early mobilization/activation following injury or surgery.***

Conversely, unnecessarily prolonged immobilization following injury or surgery may set the stage of iatrogenic CRPS. Therapy for CRPS should be directed toward the goals of physical restoration and pain control. Details regarding treatment are presented in Tables 1 and 2 located at the end of this Guideline.

### **A. Physical restoration**

Experts agree that CRPS patients usually become trapped in a vicious cycle in which guarding and activity restrictions perpetuate the pain of CRPS. Therapy for CRPS should be directed toward breaking the pain cycle by having patients participate in a progressive activation program for the affected limb.

1. Because patients usually resist using the affected extremity, the physical restoration program generally requires supervision by a physical therapist or occupational therapist.

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2. Involvement of a physical or occupational therapist is important so that repeated measurements of a patient's functional capacity can be made.
3. The frequency with which a patient receives physical or occupational therapy must be individualized by the attending physician.
4. Physical or occupational therapy occasionally continues beyond the time period during which pain control interventions such as sympathetic blocks are administered. Such prolonged therapy will be authorized as long as there is evidence of ongoing improvement of function of the limb.
5. Patients need to understand they must use their symptomatic limb in the course of their usual daily activities as well as during physical or occupational therapy sessions. Patients must commit themselves to physical restoration on a 24-hour per day basis.

### ***B. Pain control***

1. Interventions to reduce pain are typically needed so that patients can get enough relief to participate in an activation program.
2. It is crucial that pain control interventions be linked closely with physical/occupational therapy. Physical or occupational therapy sessions should be scheduled as soon as possible after a sympathetic block. The interval between block and therapy should always be less than 24-hours. In general, physical/occupational therapy should be directed toward activation and desensitization in the affected limb. Details are given in Table 2.
3. Clinicians use a variety of medications to control pain in patients with CRPS. These include alpha adrenergic blockers, corticosteroids, antidepressants, anti-seizure medications, mexiletine and opiates. The Department of Labor and Industries has no formal guideline regarding a specific medication regimen for CRPS.

### ***C. Sympathetic blocks***

1. In a patient who meets criteria for CRPS, up to 3 sympathetic blocks will be authorized to allow the attending physician to determine whether the patient has sympathetically mediated pain.
2. Additional blocks will be authorized ONLY if there is evidence from the first three that the patient has sympathetically mediated pain.
3. The physician who performs each sympathetic block should document:
  - (a) Measurable evidence that a sympathetic blockade in the target limb was achieved – e.g., hand/foot temperature before and after the block, observed color changes and/or venodilation.
  - (b) The extent and duration of the patient's pain relief, based on a pain diary.
4. A patient should be seen by a physical or occupational therapist during the time interval when a sympathetic block would be expected to have an effect – that is, within a few hours of the block. The therapist should document the functional status of the patient's symptomatic limb during the therapy session.
5. The attending physician or the physician performing sympathetic blocks should correlate the information previously described in #3 and #4 to determine whether a block has produced the intended effects on pain, function and observable manifestations of CRPS.

### ***D. Psychological treatment***

The clinical course of many patients with chronic pain, such as those with CRPS, may be complicated by pre-existing or concurrent psychological or psychosocial issues. A one time psychological/psychiatric consultation may be requested to assist in the evaluation of such patients.

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For those patients you feel require treatment for psychological/psychiatric disorders, authorization for such treatment will be considered only under the following conditions:

The psychological/psychiatric consultation has led to a psychiatric diagnosis (that is, a DSM4 diagnosis),

- AND**
- 1) **EITHER** the diagnosed psychiatric condition must be considered causally related to the industrial injury,
  - 2) **OR** the diagnosed condition must be retarding recovery from the industrial injury.

### ***E. Treatment phases***

Treatment is divided into six-week phases. A maximum of three phases may be authorized. The second phase will be authorized only if the first phase has led to demonstrable functional improvement. The third phase may be authorized only if the first and second phases have led to demonstrable functional improvement.

1. In the first six-week phase, up to 5 sympathetic blocks will be authorized (along with other accepted conservative measures such as medication management).
2. During the second six-week phase, a total of 3 sympathetic blocks will be authorized.
3. Up to 3 more sympathetic blocks may be authorized for patients who go on to the third phase of treatment.

### ***F. Hospitalization***

**Hospitalization is rarely appropriate in the treatment of CRPS.** The only exception to this is that a CRPS patient might have an orthopedic condition that is amenable to surgery. Because CRPS patients are at high risk for flares after surgery, it is reasonable for such a patient to be admitted to a hospital prior to surgery so that aggressive pain control measures may be undertaken preoperatively.

### ***G. Sympathectomy***

**Sympathectomies are not indicated for CRPS and are not covered.**

## **8. References**

1. Janig W & Stanton-Hicks M (ed) Reflex Sympathetic Dystrophy: A Reappraisal. Seattle: IASP Press, 1996.
2. Merskey H & Bogdud N (ed) Classification of Chronic Pain (2<sup>nd</sup> ed). Seattle: IASP Press 1994.

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**Table 1**

Labor and Industries

Criteria number 13

Chronic regional pain syndrome (CRPS)

Conservative treatment guideline

Examination findings & diagnostic test results	Conservative care
<p>At least <b>four</b> of the following <b>must be present</b> In order for a diagnosis of CRPS to be made.</p> <p><b>Examination findings:</b></p> <ol style="list-style-type: none"> <li>1. Temperature/color change. <i>Very Pale</i></li> <li>2. Edema. <i>Swelling</i></li> <li>3. Trophic skin, hair, nail growth abnormalities.</li> <li>4. Impaired motor function. <i>Limited motion</i></li> <li>5. Hyperpathia/allodynia. <i>Other pain</i></li> <li>6. Sudomotor changes. <i>sweating</i></li> </ol> <p><b>Diagnostic test results</b></p> <ol style="list-style-type: none"> <li>7. Three-phase bone scan that is: abnormal in pattern characteristics. for CRPS. This test is not needed. if 4 or more of the above examination. findings are present.</li> </ol> <p><b>Surgical intervention (sympathetomy) for treatment of this condition is <u>not covered</u>.</b></p>	<p>Early aggressive care is encouraged. Emphasis should be on improved functioning of the symptomatic limb.</p> <p><b>First six weeks of care:</b></p> <ul style="list-style-type: none"> <li>- Sympathetic blocks, maximum of <b>five</b>. Each block should be followed immediately by physical/occupational therapy.</li> <li>- Physical/occupational therapy should be focused on increasing functional level (see <u>Table 2</u>).</li> <li>- Other treatment, e.g., medication at MD's discretion as long as it promotes improved function.</li> </ul> <p><b>After the 1<sup>st</sup> six weeks of care:</b></p> <ul style="list-style-type: none"> <li>- Strongly consider psychiatric or psychological consultation if disability has extended beyond 3 months.</li> <li>- Continued physical/ occupational therapy based on documented progress towards goals established during first 6 weeks (referenced above).</li> <li>- Sympathetic blocks only if response to previous blocks has been positive, maximum of 3** every six weeks for a maximum of 12 weeks.</li> </ul> <p><b>**A maximum of 11 blocks can be delivered over the total 18-week period.</b></p>