COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. Division of Administrative Law Appeals

 One Congress Street, 11th Floor

 Boston, MA 02114

**DOROTHY ASARE**, (617) 626-7200

 *Petitioner* Fax: (617) 626-7220

 **www.mass.gov/dala**

*v.* Docket No: CR-12-445

**TAUNTON RETIREMENT BOARD,** Date: May 6, 2016

 *Respondent*

**Appearance for Petitioner**:

Nicholas J. Ellis, Esq.

Ellis & Associates Law Offices

8 Norwich Street

Worcester, MA 01608

**Appearance for Respondent**:

 Christopher J. Collins, Esq.

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**Administrative Magistrate**:

Angela McConney Scheepers, Esq.

**SUMMARY**

The medical panel neither lacked pertinent facts nor employed an erroneous standard in issuing the negative certificate. The Respondent’s decision to deny accidental disability retirement benefits is affirmed.

**DECISION**

Pursuant to G.L. c. 32, s. 16(4), the Petitioner, Dorothy Asare, appealed the July 27, 2012 decision of the Taunton Retirement Board (Board) to the Contributory Retirement Appeal Board (CRAB), denying her application for accidental disability retirement benefits.

A hearing was held at the Division of Administrative Law Appeal (DALA) on April 14, 2015. The hearing was digitally recorded. Ms. Asare testified on her own behalf. I marked Ms. Asare’s Pre-Hearing Memorandum “A” for identification and the Board’s Pre-Hearing Memorandum “B” for identification. I admitted Joint Exhibits 1 – 35 into evidence.

During the hearing, Ms. Asare raised psychiatric issues for the first time. The parties agreed that psychiatric issues were not addressed in the application for accidental disability retirement or its supporting Physician’s Statement, and that Ms. Asare had not been examined by a psychiatric medical panel. Ms. Asare argued that the psychiatric issues were not direct, but were a reaction to the underlying physical injury. The parties agreed that the instant appeal was not the vehicle for a psychiatric injury, and that Ms. Asare would file another application in order to address that issue. The Board objected to Ms. Asare’s proposed Exhibit 36, counseling medical records which had not been reviewed by the medical panel. I left the record open in order for the parties to submit further medical records and hard copies of photographs taken with Ms. Asare’s cell phone. The Board objected to the medical records because they were psychiatric records.

I note that pages 2-11 of Exhibit 25 comprise a psychiatric record from Peggy Chou, M.D., dated December 31, 2007. I note that Exhibit 27 is a psychiatric record from Edgardo C. Angeles, M.D., dated February 27 to October 25, 2011. The aforementioned pages of Exhibit 25 and Exhibit 27 are not relevant to this matter, and were not considered as evidence in my decision.

Both parties submitted Post Hearing Briefs and the medical records on July 17, 2015, whereupon the administrative record closed. Neither party submitted photographs. The medical records document Ms. Asare’s counseling at Community Counseling of Bristol County from January 14, 2008 until November 14, 2008. I hereby sustain the Board’s objection, and the document is marked for identification only as Exhibit 36.

**FINDINGS OF FACT**

Based on the documents admitted into evidence and the testimony presented at the hearing, I make the following findings of fact:

1. The Petitioner, Dorothy Asare, worked as a Certified Nursing Assistant (CNA) for the Taunton Nursing Home (TNH) from June 9, 2003 until she was terminated on October 6, 2006. Ms. Asare worked the 3:00 p.m. to 11:00 p.m. shift. (Exhibit 6; Testimony of Asare.)
2. According to job description for a CNA, Ms. Asare’s essential job duties were the following:
3. PERSONAL CARE, NURSING CARE AND FOOD SERVICE FUNCTIONS

Duties: Assists residents with activities of daily living including bathing, dressings, grooming, toileting, changing of bed linens, and positioning in and out of bed, chair, etc. Assists with resident recreation programs. Prepares residents for meals and snacks, assists residents in eating where needed, and records food intake.

Reads and follows daily care plans; performs assigned restorative and rehabilitative procedures; reports changes in resident condition to nurse in charge; documents care provision on resident record/flowsheets as required and reports accidents and incidents; and provided nursing functions as directed by supervisor.

1. SAFETY AND SANITARY FUNCTIONS

Duties: Understands and follows safety and sanitation rules, and promptly reports any violations to supervisor.

1. IN-SERVICE FUNCTIONS

Duties: Attend orientation and in-service as required.

1. RESIDENTS’ RIGHTS AND POSITIVE RELATIONSHIPS FUNCTION

Duties: Understands, complies with, and promotes all rules regarding residents’ rights.

Promotes positive relationships with residents, visitors and government regulators, to include presenting a professional appearance and attitude.

Physical and Sensory Requirements (With or Without the Aid of Mechanical Devices): Walking, reaching, bending, lifting, grasping, fine hand coordination, pushing and pulling, ability to communicate with residents, ability to hear and respond to resident pages, and distinguish smells, tastes and temperatures; ability to read and write; and ability to remain calm under stress.

 (Exhibit 9.) (Emphasis added.)

1. On June 1, 2005, Ms. Asare was working her regularly scheduled shift. Around 6:30 p.m., Ms. Asare and a coworker were transferring a resident from a chair to a bed when the coworker let all the patient’s weight fall on Ms. Asare. Ms. Asare overcompensated in order to prevent the resident from falling, and pulled a lower back muscle. Ms. Asare went to the nurse’s station where she was treated with Tylenol for the pain. The next day, June 2, 2005, Ms. Asare awoke to a stiff neck and pain and had to stay home from work. (Exhibits 6 and 9; Testimony of Asare.)
2. Ms. Asare called her supervisor, Diane Sullivan, to let her know of her injury and that she would not be coming in. Ms. Sullivan completed a Report of Injury form, advising within that Ms. Asare utilize proper body mechanics in the future in order to prevent injury. (Exhibit 6.)
3. On June 3, 2005, Ms. Asare went to Mill River Hospital where she was treated by Elizabeth Monteiro, M.D. Dr. Monteiro diagnosed her with a sprained back from a work-related injury and prescribed prescription Tylenol for the pain. On her follow-up visit on June 7, 2005, Dr. Monteiro assessed that based on Ms. Asare’s complaints she could have a herniated disc at C5-C6. Dr. Monteiro ordered a magnetic resonance image (MRI) study. Ms. Asare returned for a follow-up visit on June 23, 2005, reporting neck pain, stiffness and some tingling in her arm. Dr. Monteiro assessed cervical radiculopathy.[[1]](#footnote-1) (Exhibits 11 and 12.)
4. Ms. Asare’s June 29, 2005 MRI study revealed straightening of the cervical lordosis and edamatous endplate changes at the C5-C6 level; and small broad-based central disc herniation at the C5-C6 level which effaced the anterior subarachnoid space and mildly impressed the cervical cord. The other levels were normal in appearance, there was no neural foraminal stenosis, the cervical cord revealed normal signal characteristics and there was no cerebellar tonsillar ectopia. As Dr. Monteiro had assessed, there was small central broad-based herniation at the C5-C6 level. (Exhibits 11 and 12.)
5. Ms. Asare had a follow-up appointment on July 28, 2005, reporting numbness in her left arm and neck. Dr. Monteiro approved a return to work with a no lifting restriction, recommended a physical therapy evaluation and prescribed Motrin 400 mg and Flexeril 10 mg. (Exhibits 3 and 13; Testimony of Asare.)
6. Ms. Asare was scheduled for six weeks of twice weekly physical therapy sessions at Morton Hospital and Medical Center (Morton Hospital), beginning August 1, 2005. At the initial appointment, the therapist created an assessment and plan in order to decrease Ms. Asare’s pain and spasms and increase the strength in her left hand. On August 23, 2005, the occasion of Ms. Asare’s seventh visit, the therapist found functional improvements. Ms. Asare was able to dress, to sleep better, to reach up but not maintain overhead position, and to turn her head from side to side. The therapist recommended four more weeks of treatment at the same in-office frequency. (Exhibit 12.)
7. Ms. Asare received Workers’ Compensation weekly benefits from June 1, 2005 until April 24, 2006. (*See* Finding of Fact 34; Exhibit 5.)
8. On August 25, 2005, Ms. Asare was evaluated by neurologist Mazen Eneyni, M.D., of Angels Neurological Centers, P.C., upon Dr. Monteiro’s referral. Dr. Eneyni’s examination showed that Ms. Asare was not in acute distress, but had clinical left C6 radiculopathies, consistent with the June 29, 2005 MRI study. Ms. Asare had a mild degree of trigger points over her left trapezius muscle and paraspinal muscles in the cervical, thoracic and lumbar spines. She had normal range of motion of the neck. Ms. Asare had a depressed left brachioradialis reflex and decreased pinprick sensation over the left C6 area. The examination was normal otherwise. Dr. Enenyi asked Ms. Asare to continue her physical therapy regimen. He ordered an electromyogram (EMG)[[2]](#footnote-2) and a MRI study of her lumbar spine. (Exhibit 14.)
9. When Ms. Asare returned to Dr. Monteiro on September 13, 2005, the physician noted that she was still out of work upon Dr. Eneyni’s recommendation. Dr. Monteiro also noted that Ms. Asare had a kink in her back and a muscle spasm, and was still taking Flexeril. (Exhibit 13.)
10. Ms. Asare progressed with her twice weekly physical therapy sessions. On September 21, 2005, the occasion of her fifteenth appointment, the physical therapist found that Ms. Asare no longer awakened from pain. Her pain level had decreased to a 2/10 and she was able to drive. (Exhibit 12.)
11. On September 27, 2005, the physical therapist met with Ms. Asare to establish guidelines for functional therapy and the activities critical to the essential duties of her job as a CNA. The therapist reviewed activities, terms of expectations, progression, use and benefits of body mechanics, posture, pacing and endurance. The therapist established baselines for seated rows, chest press, rowing, supine – sit, sit – stand and stand – pivot. Ms. Asare met 30-50% of the goals, but demurred that she was not at her best due to a fever and a sore throat. The therapist opined that based on Ms. Asare’s progress in the physical therapy regimen, she could achieve 65% of the guidelines in two weeks and 75-100% of the guidelines within four weeks. (Exhibit 12.)
12. On September 30, 2005, Ms. Asare did not appear for her regularly scheduled physical therapy appointment. She left a message that she was “in too much pain to continue with all of the lifting” involved in the current physical therapy prescription. She stated that, “I will not hurt myself further,” and would not continue the regimen until she received the results of the second MRI and determined what was wrong. Ms. Asare never completed the physical therapy at Morton Hospital. (*See* Finding of Fact 10; Exhibit 12.)
13. Ms. Asare sought massage therapy on her own. The massage therapist recommended chiropractic care. (Exhibit 15; Testimony of Asare.)
14. On October 7, 2005, Ms. Asare underwent the second MRI study, which showed that she had minimal lumbar spondylosis without focal disc extrusion central stenosis or foraminal narrowing. (Exhibit 14.)
15. Dr. Monteiro last saw Ms. Asare on October 14, 2005 when she requested an evaluation for a return to work. Dr. Monteiro advised that Dr. Eneyni should complete the forms since Ms. Asare had remained out of work based on his advice. (Exhibit 13; Testimony of Asare.)
16. Ms. Asare saw Dr. Eneyni on October 20, 2005, January 5, 2006 and April 6, 2006. On April 6, 2006, Dr. Eneyni noted that Ms. Asare suffered from cervical radiculopathy, lumbar radiculopathy, and referred her to Dr. Bijan N. Niaki, M.D. at the Morton Hospital Pain Clinic. (Exhibits 12 and 14.)
17. Ms. Asare sought treatment with Brian R. Petrie, D.C. of Tremont Chiropractic from October 27, 2005 until December 28, 2005. (Exhibit 15.)
18. On October 27, 2005, Dr. Petrie examined Ms. Asare and found:

… signs of guarded movement patterns from sit to stand and with neck movements. … Cervical extension was limited at 48 degrees with hypermobility noted at the mid to upper cervical segments with primary areas of restriction in the upper thoracic spine upon extension. This position was most painful to the patient. … Cervical distraction was positive for increased discomfort in the cervical thoracic region. Cervical compression was positive in the neutral position for localized pain and exacerbated with coupled motions of lateral bending and rotation to either side. … Maximum nerve root tension signs appeared to within normal limits in the upper extremity. … Soft tissue palpitation revealed a significant degree of hypertonicity within in the cervical erector spinae muscles, suboccipital muscle groups more apparent on the left and cervical semispinalis cervicis and capitus muscle groups. Taut and tender fibers were noted of the upper trapezius muscles with latent trigger points present. Joint play analysis revealed segmental join dysfunction in the zygapophyseal joints of the mid-cervical spine and upper thoracic costovertebral joints. Static neck endurance test revealed weakness of the deep neck flexors.

(Exhibit 15.)

1. Dr. Petrie diagnosed Ms. Asare with chronic cervicothoracic segmental joint dysfunction. Dr. Petrie proposed a treatment plan of spinal manipulative therapy (SMT) with active release and other soft tissue release procedures three times per week for a period of four weeks, to be followed by a re-evaluation. Dr. Petrie’s treatment goal was the reduction of Ms. Asare’s pain by 50% and the increase of her range of motion and function within the first two weeks; and to return her to work within 4-8 weeks. (Exhibit 15.)
2. On November 30, 2005, Dr. Petrie re-evaluated Ms. Asare, more than four weeks after her first evaluation. He wrote in the re-evaluation:

… she relates an overall 70% improvement in regards to her symptomatology since she has begun treatment in this office. A functional rating index was also performed showing … an increase in functional status of 50% from initial evaluation. She states her overall well-being has improved significantly and she has been able to significantly reduce the amount of medication taken on a daily basis. She continues to receive massage therapy on a weekly basis. Although improvement is noted she states that her pain is still constant, however, the intensity is significantly reduced. She no longer relates symptomatology into the upper extremity. She also states that she has been more consistent with home exercise and has been performing light aerobic activity to her tolerance.

During ambulation and sit-to-stand position, Ms. Asare no longer presents with guarded movement patterns. … There is mobility noted at the cervicothoracic junction upon extension. This is no longer the most painful position for Ms. Asare…. Cervical distraction is negative for increased discomfort. Cervical compression is still positive in the neutral position and is exacerbated with coupled motion of lateral bending and rotation. … Maximum nerve root tension signs were within normal limits. Soft tissue palpation revealed significant improvement and soft tissue resiliency within the cervical erector spinae, suboccipital muscle groups, semispinalis cervicis and capitis muscles. Significant improvement is also noted at the upper trapezius, levator scapulae muscle with decreased trigger point activity. Joint play analysis reveals significant improvement in zygapophysial joint junction. However, there is restriction still present within mid-cervical region and upper costovertebral joints. The static neck endurance test revealed improved strength; however weakness is noted with repetitive turning and repetitive flexion.

(Exhibit 15.)

1. Due to Ms. Asare’s improvement, Dr. Petrie reduced the in-office frequency of her treatment plan from three times per week to twice weekly for the next three weeks. In order to continue the improvement of intersegmental joint motion, reduce symptomatology, and function status, Dr. Petrie proposed to treat Ms. Asare with SMT, soft tissue procedures with reiteration of home exercises and progression of in-office exercises to strengthen the deep neck flexors and mid to lower scapula stabilizers. Dr. Petrie informed Ms. Asare of his short term goal to improve her functional ability and reduce symptomatology, with a long term outcome enabling her to full work status within three to four weeks’ time. Ms. Asare informed Dr. Petrie that she had to undergo a functional capacity evaluation (FCE) with occupational health services. Dr. Petrie found that Ms. Asare’s overall prognosis was good, and advised her to schedule the FCE for three weeks after her last chiropractic treatment. (Exhibit 15.)
2. On December 9, 2005, Ms. Asare reported mild discomfort in the thoracic region brought on by performing increased home activities, including vacuuming. Dr. Petrie found that she had mildly exacerbated her condition and advised her to maintain the predetermined schedule. (Exhibit 15.)
3. On December 16, 2005, Ms. Asare reported acute right low back pain and buttock pain, likely due to performing grocery shopping and leaning into her motor vehicle to load them. Dr. Petrie noted a spasm within the Gmax muscle with active trigger points. Dr. Petrie treated her with electrical muscle stimulation and ice for the Workers’ Compensation injury only, and recommended the use of ice at home for the new injury. (Exhibit 15.)
4. By December 19, 2005, Ms. Asare continued to improve. She reported that she was able to progressively increase her household duties with less discomfort as the day progressed, although increased housework that required heavy lifting caused soreness within the thoracic and medial to the left scapular region. Ms. Asare reported pain in the right hip region, unrelated to the work place injury, and stated that she was using ice and pain medication to reduce the discomfort. Dr. Petrie advised ice and mild stretching to alleviate the pain in the right hip region. Ms. Asare mentioned that she mention the new injury when she attended her massage therapy appointment later that day. (Exhibit 15.)
5. On December 28, 2005, Dr. Petrie completed a final narrative report for Ms. Asare. He wrote:

Ms. Asare was initially responding favorably with treatment within this office. … She stated today that there has been gradual increase of dull aching pain in the area of the cervical, thoracic, and upper left extremity. She has been relating consistent pain in the lumbar spine. She states that this pain has been aggravated with her attempts to increase her normal daily activities. She continues with massage therapy, which she stated provides her with temporary relief.

OBJECTIVE FINDINGS:

Cervical range of motion performed with dual inclinometers revealed cervical ranges of motion increased in all planes. However, the patient is relating discomfort on extreme range of all planes with mild tight end feels noted. Cervical distraction and cervical compression is negative. There is some degree of taut and tender fibers within the paraspinal cervical musculature more apparent on the left with minimal latent trigger point activity. Active thoracolumbar ranges of motion were considered to be full in all planes; however, the patient relates discomfort on extreme range in flexion extension, and left lateral bending. Mild hypertonic fibers are noted within the paraspinal muscles more apparent on the left without trigger point activity. ... Joint play analysis reveals significant improvement in zygapophysial joint function within the cervical and thoracolumbar region. There are mild residual restrictions of the left upper costovertebral joints.

ASSESSMENT:

1. Chronic cervical/thoracic segmental joint dysfunction associated with myofascial pain disorder resultant from sprain/sprain injury – improved.

PLAN:

At this juncture I feel that Ms. Asare has reached maximum end-benefit with chiropractic treatment and has been released from active care within this office. It is advisable that she continue with the massage therapy and physical therapy. There is a possibility that Ms. Asare may be experiencing fear avoidance of work feeling she may increase her injuries when returning to work. However, I have reassured her that this is not likely to take place and that her injuries have significantly resolved. Due to possible fear avoidance, I have recommended that Ms. Asare consult a psychologist to help her cope with this possible disorder.

(Exhibit 15.)

1. On May 6, 2006, Ms. Asare saw Dr. Niaki at Morton Hospital Pain Clinic as referred by Dr. Eneyni. She informed the physician that her insurance had refused to pay for cervical epidural steroid injections. Upon examination, Dr. Niaki diagnosed Ms. Asare with cervical radiculopathy, left suprascapular nerve block and infraspinatus and mid-thoracic paravertebral trigger points. Dr. Niaki treated Ms. Asare with injections to the two trigger points located in the left suprascapular nerve block, and an injection in the left paravertebral mid-thoracic muscle. Dr. Niaki advised that Ms. Asare return for evaluation the following week, and submitted a request to the insurance company so that he could administer the cervical epidural steroid injections to Ms. Asare. (Exhibit 12.)
2. Workers’ Compensation declined approval for the cervical epidural steroid injections. Ms. Asare continued to treat with Dr. Eneyni, and take Tylenol and Motrin for the pain. She attended the Morton Hospital ER on May 26, 2006 for headache, head and neck pressure. She was discharged the same day and advised to take medication as directed and follow-up with her doctor. (Exhibits 12 and 14.)
3. After submission to Ms. Asare’s insurance company, approval for the cervical epidural steroid injection was granted. Dr. Niaki administered the cervical epidural steroid injection to Ms. Asare on June 28, 2006. (Exhibit 21.)
4. On July 10, 2006, Ms. Asare treated with orthopedic surgeon Christopher M. Bono, M.D. at Brigham and Women’s Hospital. He diagnosed minimal cervical spondylosis most prominent at C5-C6, where central disc protrusion effaced the ventral CSF space and minimally contracted the cord. He was concerned that the June 29, 2005 MRI study that Ms. Asare had produced was more than one year old, and wanted to re-evaluate Ms. Asare after reviewing a more recent study. (Exhibit 22.)
5. On July 17, 2006, Ms. Asare returned to Dr. Bono with the July 10, 2006 cervical MRI study revealed minimal cervical spondylosis and a tiny central disc protrusion at C5-C6, a complete resolution of the cervical disc herniation. During the examination he performed that day, Dr. Bono found that Ms. Asare’s condition was stable, and there was no indication for any type of surgery. (Exhibits 14 and 22.)
6. Upon a request from her employer, Dr. Bono submitted documentation to TNH that Ms. Asare was cleared to return to work on September 20, 2006. (Exhibit 35.)
7. Ms. Asare received Workers’ Compensation benefits in the amount of $392 weekly from June 1, 2005 until April 24, 2006. On May 15, 2006, she returned to work on light duty with the duty of feeding patients. She was restricted from pushing or pulling, and from carrying trays. She believed that her co-workers were unsympathetic because she could not assist in delivering food trays to residents. (Exhibit 5; Testimony of Asare.)
8. While on light duty, Ms. Asare received weekly benefits pursuant to § 35 in the amount of $314. Ms. Asare left two weeks later on June 6, 2006. When she failed to return to work, her section 34 benefits were discontinued on June 13, 2006. (Exhibit 5; Testimony of Asare.)
9. In a letter dated September 22, 2006, John A. Brennan, the City Administrator, informed Ms. Asare that she was cleared to return to work on October 2, 2006 for the 3:00 p.m. to 11:00 p.m. shift. Her benefits were discontinued under § 8(2)(d) on October 1, 2006. (Exhibit 7.)
10. When Ms. Asare failed to return to work, Mr. Brennan scheduled a termination hearing for October 6, 2006. Mr. Brennan served as the hearing officer. (Exhibit 8.)
11. Ms. Asare testified at the October 6, 2006 termination hearing about her continuing health issues. TNH officials presented return to work documents from Dr. Bono. Mr. Brennan found that Ms. Asare’s explanations did not match the physician’s return to work clearance documentation. In a letter also dated October 6, 2006, Mr. Brennan terminated Ms. Asare’s employment for failure to return to work after being cleared by her own physician. (Exhibits 8 and 35.)

*Medical Treatment after Termination*

1. Ms. Asare returned to Dr. Bono on October 26, 2006. Based on the medical record and his July 17, 2006 examination, he thought that Ms. Asare had returned to work. Ms. Asare reported that she was suffering from residual pain based on her previous complaints, but had no new medical complaints. Dr. Bono examined Ms. Asare, found that she did not qualify as a surgical candidate, and referred her to the psychiatry department for a functional evaluation. (*See* Finding of Fact 31-33; Exhibit 22.)
2. After her termination, Ms. Asare continued to see Dr. Eneyni. On May 11, 2007, Ms. Asare underwent a cervical x-ray. The cervical x-ray showed no fracture or malalignment; the flexion and extension views did not show evidence of instability; there was mild disc space narrowing and osteophyte formation at C5-C6 and there was mild spondylosis at C5-C6. On July 5, 2007, Ms. Asare reported that her right thigh pulled when she walked. Dr. Eneyni prescribed Percocet. (Exhibit 14.)
3. In July 2007, Miguel Zialcita, M.D. performed an EMG of Ms. Asare’s upper extremities and found no pathology. (Exhibit 26.)
4. Ms. Asare saw Dr. Eneyni again on August 24, 2007, and complained that her headaches were getting worse and accompanied by nausea or vomiting. Ms. Asare complained of her right thigh pulling, and agreed to an EMG. Dr. Eneyni prescribed Frova for the migraines. (Exhibit 14.)
5. In September 2007, Dr. Eneyni conducted the second EMG of Ms. Asare’s upper extremities in three months, and found no nerve damage. (*See* Finding of Fact 39; Exhibits 23 and 26.)
6. On October 24, 2007, Ms. Asare saw Dr. Eneyni, complaining of right hip pain that made it difficult to get in and out of a car, or get up from a sitting position. She was disappointed that the EMG had not been therapeutic in ending the pain. Ms. Asare had no further complaints of headache. She wanted no further testing, but requested a Percocet prescription. On November 29, 2007, Ms. Asare reported hospitalization at Morton Hospital two weeks before for headaches and a breakdown. She had no further headaches at the present time, but her right hip pain continued. (Exhibit 14.)
7. On November 11, 2007, Ms. Asare went to Morton Hospital ER with aches in the neck, head and back. She was released and advised to take Flexerol and Percocet as needed. (Exhibit 12.)
8. At her January 29, 2008 appointment with Dr. Eneyni, Ms. Asare reported right hip pain. Dr. Eneyni renewed her pain prescriptions in addition to prescribing Lyrica. (Exhibit 14.)
9. On January 31, 2008, Ms. Asare underwent an x-ray at Brockton Hospital to evaluate the source of her right hip pain. The x-ray revealed bilateral degenerative joint disease involving the hip joints (arthritis), more pronounced on the left but also evident on the right with joint space narrowing in the weight-bearing portion of the hip joints, subchondral cyst formation and sclerosis. There was no fracture demonstrated or other acute abnormality. (Exhibit 14.)
10. On April 10, 2008, Dr. Eneyni discussed the January 31, 2008 x-ray with Ms. Asare. Ms. Asare complained of fever and chills, back pain, difficulty walking and requested oxycodone. Dr. Eneyni prescribed one last prescription for oxycodone until Ms. Asare got an orthopedic evaluation. (Exhibit 14.)
11. Ms. Asare had an x-ray of the sacrum and coccyx. There was negative plain film of the SI joints and osteoarthritis of both hips. There was no significant degenerative disc disease or arthritic change, and no compound compression fracture. Dr. Eneyni diagnosed Ms. Asare with (1) hip pain, secondary to arthritis; (2) cervical spine disease without myelopathy, MRI showed small disc protrusions. (Exhibits 12 and 14.)
12. On January 9, 2009, Ms. Asare underwent an MRI study of the lumbosacral spine. The study demonstrated disc desiccation at L3-4. There was no evidence of any significant disc bulging or herniation, there was no compression fracture of vertebral body edema. There was no foraminal narrowing. Ms. Asare underwent an EMG and nerve conduction evaluation at Dr. Eneyni’s request. The study was normal with no electrical evidence of right lumbosacral radiculopathy or peripheral neuropathy. The reported electro diagnostic findings were (1) normal right sural and right superficial peronal sensory responses; (2) normal right posterior tibial and right common peroneal motor responses; and normal EMG of the right leg. Ms. Asare was unable to tolerate additional needle examination. (Exhibits 12 and 14.)
13. Ms. Asare’s last appointment with Dr. Eneyni is dated April 3, 2009 in the record. She complained of back pain, joint pain, leg pain at night, and leg pain with exertion. Ms. Asare complained of vertigo and frequent headaches. She reported that the orthopedist recommended a hip replacement in order to alleviate her right hip pain. (Exhibit 14.)
14. Ms. Asare returned to Dr. Bono on December 18, 2008, more than two years since her last visit. From her repeat MRI, he found that she had no substantial compromise or compression of the spinal cord and the nerve root, and presented with mild degeneration mid cervical spine. Again, he did not recommend any type of surgery. (*See* Findings of Fact 31-33 and 39; Exhibit 22.)
15. Ms. Asare sought treatment at Bay State Pain Associates for pain management of her neck and upper extremity under the care of Sherif Algendy, M.D. On July 15, 2009, Ms. Asare had a C5-5 epidural steroid injection. On July 29 and August 17, 2009, she had left L3,-4, 4-5, 5-S1 facet injections. On August 26, September 23, October 7 and 21, 2009, October 14, 2010, she underwent radio frequency ablation of the left L3, L4, and L5 medial branch and dorsal ramus for lumbar spondylosis. On December 10, 2009, Ms. Asare underwent a bilateral sacroiliac joint injection for right sacroilitis. October 14, 2010, she underwent radio frequency ablation of the left L3, L4, and L5 medial branch and dorsal ramus again. On November 29, 2010, Ms. Asare reported 90% relief of her back pain, but complained of pain in her neck going down both shoulders and shoulder blades. Dr. Algendy recommended a C5-5 epidural steroid injection. On January 6, 2011, Ms. Asare underwent the injection, and repeated the procedure on February 24 May 26, 2011. On July 25, 2011, she underwent a bilateral L4-5 transforaminal epidural injection. (Exhibit 31.)
16. Beginning April 28, 2010, Ms. Asare attended New England Sinai Hospital for 16 physical therapy appointments. Regina Rizoli, P.T. evaluated Ms. Asare with acute exacerbation of neck pain with severe muscle reactivity to adjacent musculature, loss of functional movement and effective motor control, as well as lost function. Ms. Rizoli created a regimen of aquatic exercises and home exercises. (Ms. Asare’s health insurance approved 20 twice-weekly visits.) By the date of her final appointment on June 28, 2010, Ms. Rizoli found that Ms. Asare had made good progress with all aspects of the prescription with increased range of motion, strength and decreased muscle reactivity. Ms. Asare was able to manage her pain due to the aquatic based program. (Exhibit 32.)

*Independent Medical Examinations*

1. Roland R. Caron, M.D., evaluated Ms. Asare on December 23, 2005. Ms. Asare reported pain on the left side of her neck and down the left shoulder blade due to the work-related incident. A physical examination revealed marked tenderness of the trapezius muscle. The trapezius muscle was also enlarged and swollen due to the spasm in the left side of her neck posteriorly. Dr. Caron diagnosed Ms. Asare with acute cervical strain with post-traumatic myofascitis of the trapezius muscle in her neck on the left. Dr. Caron opined that Ms. Asare’s disability was causally related to the work-related incident, was permanently disabled from her strenuous duties as a CNA, but could be retrained to do some other type of work. (Exhibit 16.)
2. At the request of her counsel, Errol Mortimer, M.D. performed IMEs of Ms. Asare on March 4, 2006, September 26, 2008, May 8, 2009, March 6, 2010 and August 26, 2011. He later submitted the Physician’s Statement for her accidental disability claim, attaching the August 26, 2011 IME as an addendum. (*See* Finding of Fact 92; Exhibits 5 and 17.)
3. At the first examination on March 4, 2006, Ms. Asare reported pain in her neck, upper back and left periscapular region, which was aggravated by activity. She also reported numbness in her left arm, which occurred during sleep or when the arm was elevated to the height of her shoulders. (Exhibit 17.)
4. During the March 4, 2006 physical examination, Dr. Mortimer found no abnormality of the spine and no suggestion of spasm. Ms. Asare was able to rotate her neck to each side and laterally flex her neck to each side. She had difficulty in reaching her chin down to touch her chest. Ms. Asare had one area of exquisite tenderness on the medial aspect of the scapula about 2/3 of the way from the top to the distal angle. This area was reproducibly painful and she suffered minimal pain when the shoulder was put through a passive range of motion. (Exhibit 17.)
5. Dr. Mortimer opined that Ms. Asare had sustained a neck, left shoulder and abdominal injury on June 1, 2005. He found that her original complaints were consistent with the mechanism of injury, and that most of her symptoms had resolved. Ms. Asare’s neck pain had improved, and her abdominal pain had resolved completely. (Exhibit 17.)
6. Dr. Mortimer found her residual symptoms of periscapular pain and associated numbness difficult to explain given her original injury. Dr. Mortimer had no x-rays to review and an MRI study was pending. Dr. Mortimer was aware that Ms. Asare was seeing a neurologist and that there was discussion of a nerve conduction study or an EMG. He found that Ms. Asare was partially temporarily disabled, but able to perform light duty if available. (Exhibit 17.)
7. There was no change in Ms. Asare’s condition when Dr. Mortimer conducted a second IME on September 26, 2008. Once again, Dr. Mortimer had no access to x-rays and imaging studies. (Exhibit 17.)
8. Dr. Mortimer conducted a third IME on May 8, 2009. He reviewed Ms. Asare’s recent cervical spine MRI which demonstrated multiple bulging discs. She had new complaints of neck pain radiating into both shoulders, the left shoulder greater than right; severe headaches emanating from her neck pain; and thoracic and lumbar back pain radiating into both hips. Ms. Asare described multiple epidural and intramuscular injections that failed to relieve her pain. She reported that she had learned from her many consultations that she was not a candidate for spinal surgery, and that she had to undergo bilateral total hip replacements due to arthritis in both hips. She complained that her hip pain had progressed from the bilateral pain of previous MRI studies to greater pain on the right hip. Without access to x-rays, Dr. Mortimer could not form a medical opinion on Ms. Asare’s hip arthritis or hip pain. (Exhibit 17.)
9. Ms. Asare complained that the pain in her neck, upper back and left periscapular region was aggravated with activity, but improved when she was at rest. She reported that her neck and shoulder pain was virtually always present, and the thoracolumbar pain was present at most times. She complained of numbness in her left arm, especially due to sleep, and weakness in her left arm. (Exhibit 17.)
10. Dr. Mortimer found that Ms. Asare’s thoracic and lumbar back pain was related to her cervical and cervic thoracic symptoms, and was causally related to her injury. The residual symptoms of cervical, thoracic, lumbar, shoulder and periscapular pain were secondary to the original neck strain, and by Ms. Asare’s report, the cervical disc disease noted on the MRI study. (Exhibit 17.)
11. Dr. Mortimer opined that Ms. Asare had met maximum medical improvement, and had a residual permanent impairment. Based on AMA Guidelines to the Evaluation of Permanent Impairment, 5th Ed., Dr. Mortimer found that Ms. Asare had a DRE spine, category III; DRE thoracic spine, category II and a DRE lumbar spine, category II. This represented a 52% impairment of the cervical spine corresponding to an 18% impairment of the whole person; a 40% impairment of the thoracic spine corresponding to an 8% of the whole person; and an 11% impairment of the lumbar spine corresponding to an 8% impairment of the whole person. The combined impairment based on the combined values chart equaled 31%. (Exhibit 17.)
12. Dr. Mortimer prepared for his fourth March 6, 2010 IME of Ms. Asare by reviewing his previous IME reports; Dr. Algendy’s records from Bay State Pain Clinic, dated July – October 2009; and the Rhode Island Hospital May 13-14, 2009 records of Ms. Asare’s thyroidectomy. Ms. Asare had had no recent imaging studies. (Exhibit 17.)
13. Since the third IME on May 8, 2009, Ms. Asare had received 8-10 injections in her neck and back, but reported continued pain in both areas. Her neck pain, aggravated by activity, continued to radiate into the shoulders and elbow and improved with rest. Ms. Asare continued to have numbness in her left arm, especially noticeable after sleep. Ms. Asare’s total combined impairment, based upon the AMA Guidelines to the Evaluation of Permanent Impairment, remained the same at 31%. Dr. Mortimer’s opinion that the residual symptoms of cervical, thoracic, lumbar, shoulder and periscapular pain were secondary to the original neck strain remained the same. Ms. Asare reported that total hip replacement surgery had been recommended. Without records, Dr. Mortimer could give no definitive statement on Ms. Asare’s hip problems. (Exhibit 17.)
14. Dr. Mortimer prepared for his fifth and final August 26, 2010 IME of Ms. Asare by reviewing his previous IME reports; Bay State Pain Clinic medical records dated July 15, 2009 to October 14, 2010; Dr. Shapiro’s March 26, 2010 IME; Dr. Birbiglia’s March 11, 2010 IME; New England Sinai Hospital physical therapy records dated April 28 – October 29, 2010 and Dr. Angeles (Exhibit 27, which has been excluded from evidence) (Exhibits 17, 24, 31-33.)
15. On April 20, 2006, Cameron M. Govonlu, M.D. evaluated Ms. Asare for Workers’ Compensation. Ms. Asare reported that she had attended physical therapy for six months after the work-related injury, and is currently undergoing massage therapy with good results. She reported current symptoms of numbness in both arms, weakness of her left arm and wrist, constant pain which is exacerbated by standing, bending, climbing stairs, lying on her left side, cold/damp weather, lifting and overhead activity. She also reported sleep interruption due to the pain, and occasional neck and upper back stiffness in the mornings. Ms. Asare also reported fever, chills, general weakness, recent weight gain, eye redness, ringing in the ears, dry mouth, stiff joints, excessive hair growth and recurrent headaches. The headaches were pounding in nature, lasting two to four hours, and were triggered by bright light, exercise, increased physical activity and travel. (Exhibit 19.)
16. Dr. Govonlu diagnosed Ms. Asare with post-traumatic injury of upper back and neck with residual left-sided scapuloscostal syndrome. He noted that the chiropractic manipulation improved the condition. He ruled out left lower cervical facet joint related pain. He recommended a simple injection of the left levator scapular and two trigger points in left infra spinata muscles before returning for another evaluation. (Exhibit 19.)
17. On June 21, 2006, Ms. Asare was evaluated by Tony Tannoury, M.D. for Workers’ Compensation. Ms. Asare reported that she had been treating for the work-related incident non-operatively for the past year with a chiropractor, physical therapy and non-steroids. Ms. Asare reported transient symptoms of numbness and tingling all the way down to the left thumb and index finger. Dr. Tannoury found midline and left paraspinal tenderness. (Exhibit 20.)
18. Dr. Tannoury diagnosed C5-C6 disc herniation based upon the June 29, 2005 MRI, and noted that Ms. Asare did not have any significant foraminal stenosis. Dr. Tannoury was concerned because the MRI was almost one year old, and wanted to review the extent of the C5-C6 disc herniation to see if other levels were involved. Ms. Asare wanted to proceed with surgery because of the failure of the non-operative treatment. The doctor advised her of the risks and benefits of the surgery, and advised no action until she underwent another evaluation based on a new MRI. (Exhibit 20.)
19. Vincent Birbiglia, M.D. evaluated Ms. Asare on September 18, 2007, October 9, 2008 and March 11, 2010 upon request of her counsel. On September 18, 2007, Dr. Birbiglia noted that chiropractic care, massage therapy, physical therapy and epidural pain clinic injections had not alleviated Ms. Asare’s cervical and left shoulder pain to any significant degree. Ms. Asare reported that she suffered significant pain that prevented her from functioning. He reviewed the June 29, 2005 MRI study which demonstrated a small disc herniation at C5-C6, and October 2005 MRI which demonstrated a broad osteophyte protrusion. Dr. Birbiglia recommended that Ms. Asare try the epidural pain clinic injections again, but she declined. He concluded that Ms. Asare was permanently and totally disabled from returning to her previous occupation. (Exhibit 24.)
20. On October 9, 2008, Dr. Birbiglia changed his opinion and found that Ms. Asare was temporarily totally disabled, and that she had not reached a medical end point. He recommended epidural injections, but noted that Ms. Asare was reluctant to try them again. He asked for the June 10, 2006 MRI study of the cervical spine in order to complete his diagnosis. (Exhibit 24.)
21. At the March 11, 2010 appointment, Dr. Birbiglia reviewed further medical records including records from Baystate Pain Associates, documenting cervical, lumbar facet and sacroiliac injections; an April 4, 2009 psychiatric IME performed for the Industrial Accidents Board by Alicia D. Powell, M.D.; a May 8, 2009 IME from Dr. Mortimer and May 2009 hospital admission records from Rhode Island Hospital. (Exhibits 17, 24 and 31.)
22. Dr. Birbiglia noted that Ms. Asare complained of depression and that her drug regimen included psychotropic agents. Ms. Asare continued to have relief from chronic cervical and lumbar pain due to the lumbar epidural steroid injections. Dr. Birbiglia also found that Ms. Asare had mild extrapyramidal Parkinsonian syndrome, which could have developed as a result of the psychotropic medications. He noted that these symptoms could remain and become permanent even after cessation of the medications. He attributed the extrapyramidal Parkinsonian syndrome to the use of those medications because of Ms. Asare’s young age. (Exhibits 24 and 31.)
23. Dr. Birbiglia’s opinion of temporary total disability, made after his second evaluation of Ms. Asare, remained unchanged. (Exhibits 24 and 31.)
24. Steven A. Hoffman, M.D. and Kathleen W. Hoffman, R.N, MSN, CS of Northeast Psychiatric and Forensic Services performed three psychiatric and pain evaluations of Ms. Asare for her Workers’ Compensation claim. For the first evaluation, the Hoffmans examined Ms. Asare on September 25, 2007 and January 9, 2008, and reviewed the medical records from Morton Hospital and Medical Center Rehabilitation Services, Dr. Petrie, Dr. Heller, Dr. Eneyni, Dr. Bono, Dr. Mortimer and Dr. Menon. Ms. Asare complained of pain in the upper back of her head, along her collar bones, the back of her neck, left breast area, below her left scapula, down the lateral aspect of her left arm, in her left antecubital fossa, in her right hip, mid back, lower back, down the lateral aspect of her thigh, in her left ankle, feet and numbness in the left arm when asleep or when arm is above shoulder level. Ms. Asare reported that her pain ranged from 8/10 to 10/10; that her medications, Cymbalta, Lyrica and oxycodone provided her with 10% relief of her pain, 40% if she were lying down; and that her pain interfered with her overall daily function at an intensity level of 65/70 or 93%. Ms. Asare described her treatment so far: physical therapy three times per week for ten weeks; chiropractic treatment twice a week for four months; massage therapy twice a week for one year; three MRI studies; four or five epidural steroids injections and two EMGs. (Exhibit 26.)
25. Dr. Hoffman diagnosed Ms. Asare’s physical symptoms as disc herniation, C5-C6 with spinal cord impingement and mild spondylosis of C5-C6 and minimal lumbar spondylosis. He opined that Ms. Asare’s condition was causally related to her injury on June 1, 2005. He found that based on the pain in several locations of her body and the pain intensity of 9/10, Ms. Asare was completely disabled at the current time. Dr. Hoffman recommended treatment at a pain clinic and any work-ups, procedures and/or surgery as deemed necessary by an appropriate specialist. (Exhibit 26.)
26. For his second evaluation of Ms. Asare on June 25, 2008, Dr. Hoffman was provided with additional medical records: the June 21, 2006-December 31, 2007 records from Boston Medical Center and the September 18, 2007 IME from Dr. Birbiglia. Ms. Asare also reported an incident that took place before Dr. Hoffman’s first evaluation. She narrated that back in September 2007 she suffered an incident of leg paralysis for about an hour, was unable to get out of bed and suffered pain from her hips to her knees. That incident had led to her second EMG. Ms. Asare reported severe and debilitating pain, and a painful April 2, 2008 chiropractic visit. (Exhibit 26.)
27. Dr. Hoffman’s recommendations remained unchanged after the June 25, 2008 IME. (Exhibit 26.)
28. Dr. Hoffman had no additional medical records for his third medical evaluation, dated October 15, 2008. Dr. Hoffman’s opinion and recommended course of treatment remained the same. (Exhibit 26.)
29. On May 26, 2010, Ms. Asare was evaluated by Gilbert L. Shapiro, M.D., an orthopedic surgeon, for Workers’ Compensation. Dr. Shapiro reviewed the June 29, 2005 MRI of the cervical spine which showed small central broad based disc herniation at the C5-C6 level; the October 7, 2005 MRI of the lumbosacral spine which showed some minimal lumbar spondylolysis without focal disc extrusion; the July 10, 2006 MRI of the cervical spine which showed minimal cervical spondylosis most prominent at C5-C6 with a tiny central disc protrusion; and the September 18, 2008 cervical spine and January 9, 2009 lumbosacral MRI studies which showed essentially the same pathology. He also reviewed the x-rays which Ms. Asare brought with her; the reports from Boston Medical Center and Bay State; Dr. Heller’s April 10, 2006 IME; reports from physicians to Ms. Asare’s counsel; and multiple reports from treating physicians including Dr. Bono, Dr. Petrie and Dr. Birbiglia. (Exhibit 33.)
30. Ms. Asare complained of difficulty in her neck, arms, lower back and both hips, with symptoms more pronounced in the left hip. Ms. Asare stated that she had been out of work due to a June 1, 2005 work-related injury, returned for a two week period and was unable to manage, and had not worked since that time. She reported conservative management including chiropractic treatment, an annual two-week physical therapy regimen, and temporary relief due to epidural injections. (Exhibit 33.)
31. Dr. Shapiro diagnosed Ms. Asare with (1) acute cervical and lumbosacral strain devolved; (2) pre-existing degenerative cervical disc disease 5-6; (3) spondylosis lumbosacral spine; and (4) psychiatric abnormalities. (Exhibit 33.)
32. In regard to causality, Dr. Shapiro opined that Ms. Asare had pre-existing degenerative changes in both the cervical and lumbosacral spine, which were aggravated by the June 1, 2005 work-related incident. That acute episode was resolved many years ago, and the residual complaints are secondary to her pre-existing degenerative changes. Dr. Shapiro found that Ms. Asare was not totally disabled; she could sit, stand, walk and bend. She had full use of her upper extremities. She could lift 10-20 lbs., but not on a repetitive basis. Dr. Shapiro advised that Ms. Asare refrain from awkward positions of her cervical spine. He opined that she required no further ongoing active treatment of either the cervical spine or the lumbosacral spine as that problem had reached an end result. (Exhibit 33.)
33. On January 19, 2012, Ms. Asare was evaluated again by David Heller, M.D., an orthopedic surgeon. Before the examination, Dr. Heller reviewed physical therapy reports, Dr. Bono’s records, the IMEs of Dr. Shapiro and Dr. Mortimer, and reviewed his own IME from 2008. (*See* Finding of Fact 78; Exhibit 34.)
34. Ms. Asare informed Dr. Heller that she was presently unimproved, with neck pain, worse on the left side and extending towards the back of her neck. She complained of pain radiating into both arms, including tingling in both hands; and pain in her both hips which affected her ability to sleep and limited her standing and walking ability. Ms. Asare wore a corset for her lower back pain and she used a lidocaine patch at the tip of her left scapula for upper back pain. (Exhibit 34.)
35. Dr. Heller noted that in 2008 he had found that Ms. Asare was at maximum medical improvement, and could perform light duty and possibly progress to full duty. In 2012, he found that she had deteriorated, and was not fit for any duty, even light duty now or in the future. He found that from an orthopedic perspective, the diagnosis of cervical strain and its disabilities were related to the June 2005 injury, and that the disability was total and permanent. He found that the neck injury, while a significant cause of the disability, was not the predominant cause or the only cause. Dr. Heller found that the other diagnoses, including the chronic lumbar strain, the chronic shoulder strain, the trochanteric bursitis and the muscular deterioration were causally related to the June 2005 injury. (Exhibit 34.)

*Application for Accidental Disability Retirement*

1. On August 24, 2011, Ms. Asare filed a Member’s Application for Disability Retirement (Application), claiming that she was suffering from “cervical spine disc herniation.” In the Application, Ms. Asare stated that as a result of her disability, she was unable to perform ‘lifting, pulling, long standing, long sitting, running, fast walking, bending for a long time, standing[,] shower.” She stated that she did not know when she became unable to perform these duties. She also stated that she had limited medical rehabilitation activities, limited daily living activities, no sports or other strenuous activities and no other employment since the onset of her disability. (Exhibit 3.)
2. The Treating Physician’s Statement was submitted by Dr. Mortimer. The statement was dated September 21, 2011, with an August 26, 2011 IME attached as an addendum. (*See* Findings of Fact 56-68; Exhibit 4.)
3. In the Physician’s Statement, Dr. Mortimer stated that Ms. Asare was last able to perform the essential duties of her position on June 1, 2005, and that she could no longer lift, carry, walk, sit or stand for prolonged periods of time without restrictions. He noted that Ms. Asare was symptomatic of chronic, stable cervical, thoracic and lumbar pain that had persisted for years. He noted that his diagnosis of Ms. Asare’s cervical radiculopathy, thoracic and lumbar strain was confirmed by a MRI of the C-spine. He opined that Ms. Asare, whose treatment since 2009 had consisted of alternative lumbar and cervical epidural steroid injections every six weeks, was at a medical end point. (Exhibit 4.)
4. Dr. Mortimer noted that the addendum, an August 26, 2011 IME following up on his earlier March 4, 2006, September 22, 2006, September 26, 2008, May 8, 2009 and March 6, 2010 IMEs, was prepared after reviewing Dr. Shapiro’s March 26, 2010 orthopedic IME, Dr. Birbiglia’s March 11, 2010 neurological IME, medical records from New England Pain Associates dated July 15, 2009 to October 14, 2010, physical therapy records from New England Sinai Hospital dated April 28, 2010 to October 29, 2010 and psychiatric records from Dr. Angeles dated August 11, 2009 to April 21, 2011. (Exhibits 4 and 17.)
5. In the addendum, Dr. Mortimer noted that Ms. Asare experienced temporary relief from the cervical and lumbar spine injections, which she received alternately at three month intervals. The injections offered moderate pain relief, but her pain returned as the effects of the injections gradually wore off. When Ms. Asare was most symptomatic, her neck pain radiated into her shoulders and elbows. She awoke stiff and achy in the mornings, and took hours to feel right. Her pain increased in proportion to activity. Ms. Asare generally awoke with left arm numbness, which continued off and on throughout the day or sometimes for several days before improving. Ms. Asare’s low back pain persisted, with pain varying from 5-8/10, with relative improvement in the weeks following her injections. Ms. Asare had undergone another PT regimen in 2010, but the modest change in her pain did not last. There was ongoing discussion of bilateral total hip replacement, but Ms. Asare not yet decided to proceed. Ms. Asare had ongoing mid-thoracic pain, which was less severe than the cervical and lumbar pain. This condition was not treated specifically and pain remained at a constant dull ache, sometimes varying in intensity. (Exhibit 4.)
6. When Dr. Mortimer examined her for the purposes of the August 26, 2011 IME, Ms. Asare presented symptoms of obvious discomfort, using a cane to walk with a stiff, painful gait. Ms. Asare had no cervical deformity, but her cervical motion was limited. She had no visible atrophy, but she felt weak in her shoulder girdle muscles. Ms. Asare had no thoracic spine deformity, but had diffused aching pain throughout out paraspinal muscles and around the scapulae bilaterally. She had no lumbar spine deformity, but suffered pain to the sacroiliac joints bilaterally, pain that radiated into her buttocks and pain from her back into her bilateral hips on the side and anteriorly. (Exhibit 4.)
7. Dr. Mortimer certified to disability, permanence and causality. He wrote:

To summarize, Ms. Asare sustained acute injuries to her, left shoulder and lumbar spine on 6/1/2005 while transferring a patient from chair to bed. Her thoracic and lumbar back pain is related to her cervical and cervicothoracic symptoms. Her injury is causally related to the accident on that date. She has residual symptoms of cervical, thoracic, lumbar, shoulder and periscapular pain. These appear to be secondary to her original neck strain, and by her report, the cervical disk disease noted on her MRI. Her complaints and physical examination findings have persisted since her injury and are somewhat controlled by her schedule of alternating cervical and lumbar epidural injections every 6 weeks.

(Exhibit 4.)

1. Dr. Mortimer opined that Ms. Asare had reached maximum medical improvement, had residual permanent impairments and would not be able to return to work in any capacity. According to the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Dr. Mortimer concluded that Ms. Asare had a total impairment of 31% based on the following:

DRI cervical spine, category III: This represents a 52% impairment of the cervical spine, or an 18% impairment of the whole person.

DRI thoracic spine, category II: This represents a 40% impairment of the cervical spine, or an 8% impairment of the whole person.

DRI lumbar spine, category III: This represents a 11% impairment of the cervical spine, or an 8% impairment of the whole person.

(Exhibit 4.)

1. On November 22, 2011, Maria Gomes, the Director of Human Resources, submitted the Employer’s Statement Pertaining to a Member’s Application for Disability Retirement. Ms. Gomes described Ms. Asare’s CNA duties as caring for, feeding, bathing and assisting the residents with their daily routines. Ms. Gomes described the physical requirements of the position as assisting the residents as required, and regular bending and lifting as needed. Ms. Gomes further stated that there were no duties that Ms. Asare could not perform because she had been cleared by her physician to return to work on September 20, 2006; that Ms. Asare never returned to work; and there was no need for a modification or job duties or reasonable accommodation because Ms. Asare had been cleared to return to full duty. (*See* Finding of Fact 32; Exhibit 5.)
2. Pursuant to G.L. c. 32, §§ 6(3) and 7(1), on May 21, 2012, the Public Employee Retirement Administration Commission (PERAC) convened an accidental disability medical panel comprised of Steven H. Sewall, M.D., orthopedic surgeon; James G. Nairus, M.D., orthopedic surgeon; and Robert A. Levine, M.D., neurologist. PERAC transmitted the medical records via a compact disc. (Exhibit 10.)
3. Ms. Asare was examined by the panel physicians on June 29, 2012. The panel physicians reviewed Ms. Asare’s job description and reviewed her medical records from the time of injury on June 1, 2005. The medical records consisted of the records of (Exhibits 11-17, 20-23, 28, 31-34, 36.)
4. The medical panel answered in the negative as to disability, permanence and causation. Dr. Levine wrote the medical opinion on behalf of the unanimous panel. (Exhibit 11.)
5. Reviewing the medical records, Dr. Levine found that Ms. Asare had had an MRI study on June 29, 2005 after complaining of a job related injury on June 1, 2005. The MRI revealed a small central broad based disc herniation at C5-6. When she was evaluated by neurologist Dr. Eneyni on August 25, 2005, she complained of left scapular pain, left low back pain and neck stiffness. Dr. Eneyni felt that Ms. Asare had a depressed left brachial radialis reflex and mild trigger points over her left trapezius and paraspinal muscles of the cervical, thoracic and lumbar spines. A later October 7, 2005 lumbar MRI revealed minimal lumbar spondylosis with no central or foraminal stenosis. The March 27, 2006 EMG of Ms. Asare’s upper extremities revealed “an essentially normal study.” A July 10, 2006 cervical MRI study revealed minimal cervical spondylosis and a tiny central disc protrusion at C5-6. (Exhibit 11.)
6. During the panel examination, Ms. Asare complained of pain radiating from her neck to her waist, pain in her bilateral shoulders, weakness in her hands, and also complained that her hands “freeze” while she slept. The panel physicians noted that Ms. Asare’s most recent treatments were injections to her SI joint, her lumbar facets, RF lesions of her lumbar facets and cervical epidural steroid injections. The panel physicians also noted Ms. Asare had not worked for the past seven years. (Exhibit 11.)
7. During the physical examination, the panel physicians found that Ms. Asare had signs of symptom magnification, namely, extremely limited cervical range of motion to formal testing. To informal observation, Ms. Asare’s cervical motion was painless and full. Her reflexes were intact and the panel physicians did not notice any atrophy. Ms. Asare passed the straight leg raising test, and her Lasegue’s and Lindner’s signs were negative. The panel was cognizant of Ms. Asare’s history of cervical and lumbar pain, but found no permanent disability or loss of function. Based on the absence of objective findings to account for Ms. Asare’s complaints, the medical panel opined unanimously that Ms. Asare was not physically incapable of performing the essential duties of her job as a CNA. (Exhibit 11.)
8. On July 17 2012, PERAC forwarded the medical panel certificate to the Board. (Exhibit 11.)
9. On July 27, 2012, the Board voted to deny Ms. Asare’s application for accidental disability retirement after finding that her condition was not caused or aggravated by reason of a personal injury sustained or a hazard undergone as a result of, and while in the performance of her work related duties. (Exhibit 1.)
10. On August 15, 2012, Ms. Asare filed a timely appeal at DALA. (Exhibit 2.)

**CONCLUSION AND ORDER**

 A medical panel certificate answering in the affirmative to the questions of incapacity, permanence and causation is a condition precedent to granting an accidental disability retirement. *Quincy Retirement Bd. v. Contributory Ret. App. Bd*., 340 Mass, 56, 60 (1959).

 The purpose of the medical panel examination and certificate is to “vest in the medical panel the responsibility for determining medical questions which are beyond the common knowledge and experience of the members of the local [retirement] board.” *Malden Retirement Bd*., 1 Mass. App. Ct. 420 (1973); *Plante v. Lowell Retirement Bd*., CR-05-3 (DALA 2007). The medical panel following an examination must issue a certificate, first and foremost, regarding the applicant’s mental or physical incapacity to perform the essential duties of his job. M.G.L. c. 32, § 6(3)(a); *Malden Retirement Bd*., 1 Mass. App. Ct. at 423. Once the regional medical panel issues a proper certificate, the local retirement board is bound by the panel’s conclusion when a majority of the physicians on the panel responds in the negative to any of the three questions presented. *Malden Retirement Bd*., 1 Mass. App. Ct. at 423 n. 6. Furthermore, CRAB is bound by those findings unless the medical panel employed an erroneous medical standard in reaching its conclusions or lacked pertinent facts when it made its determination. *Id.* at 424.

 Although the medical panel certificate is not conclusive of the ultimate fact of causation, in this case, the medical panel (Drs. Levine, Nairus and Sewall) answered in the negative to the questions of incapacity and permanence. All three panel physicians reviewed the medical history of Ms. Asare and the essential duties of her job description in their determination of whether she would be physically able to continue working.

 During the June 29, 2012 examination, the panel physicians found no permanent disability or loss of function. They found no objective basis for Ms. Asare’s many medical complaints outside the initial injury. Instead they found that Ms. Asare presented signs of symptom magnification. During the examination, Ms. Asare’s cervical motion was painless and full, her reflexes were intact and the panel physicians did not notice any atrophy. Ms. Asare passed the straight leg raising test, and her Lasegue’s and Lindner’s signs were negative.

 The panel was unanimous that although Ms. Asare did indeed suffer from pain and had a limited range of motion (which the panel thought could be alleviated by the facet joint injections), she was capable of performing the essential duties of the position of certified nurse aide.

 In order to overcome the regional medical panel’s negative certificate, Ms. Asare has to prove that the medical panel lacked pertinent information or used an erroneous medical standard. *Kelley v. Contributory Retirement Appeals Bd.*, [341 Mass. 611](http://sll.gvpi.net/document.php?field=jd&value=sjcapp:341_mass._611) (1961). After a careful review of the testimony and evidence, I conclude that she has not done so.

 Although Ms. Asare did not file an accidental disability retirement application for a psychological injury and was not examined by a psychiatric panel, she raised the issue of mental injury during her April 14, 2015 hearing at DALA. I ruled that the hearing was limited to the issues as filed on appeal.

 Ms. Asare was treated by a myriad of medical providers. She was evaluated by no fewer than nine physicians for IMEs, some at the behest of her employer and Workers’ Compensation, others at the behest of her counsel.

 At the beginning of her treatment, the medical providers were hopeful of a quick recovery. I find that the medical conclusions of Dr. Monteiro, Dr. Bono and Dr. Petrie were objective in this regard. Ms. Asare first saw Dr. Monteiro on June 3, 2005. Dr. Monteiro assessed that she could have a herniated disc at the C5-C6 level, which was confirmed by a June 29, 2005 MRI study. On July 28, 2005, Dr. Monteiro approved a return to work with a no lifting restriction, recommended a physical therapy evaluation and prescribed Motrin and Flexeril. Ms. Asare did not return to work per Dr. Monteiro’s orders. When Ms. Asare requested an evaluation form for her employment on October14, 2005, Dr. Monteiro referred her to Dr. Eneyni because he had kept her out of work.

 Ms. Asare attended physical therapy at Morton Hospital from August 1, 2005 until September 27, 2005. After almost two months of treatment, Ms. Asare’s pain level had abated to 2/10, and she was able to drive. At her September 27, 2005 appointment, Ms. Asare met 30-50% of the therapist’s goals in exercises of seated rows, chest press, rowing, supine - sit, sit – stand and stand – pivot. With this progress, the therapist assessed that Ms. Asare could achieve 65% of the guidelines in two weeks and 75-100% of the guidelines within four weeks. On September 30, 2005, Ms. Asare stopped treatment, and informed the therapist that she was waiting for the results of a MRI study before resuming treatment.

Dr. Bono first saw Ms. Asare on July 10, 2006, when she presented an MRI study that was more than one year old. When she produced a later MRI on July 17, 2006, Dr. Bono found a complete resolution of the cervical disc herniation. He found that Ms. Asare’s condition was stable, and there was no indication for any type of surgery. On September 20, 2006, Dr. Bono cleared Ms. Asare for a return to work.

 Ms. Asare underwent a second round of physical therapy with Dr. Petrie from October 27, 2005 until December 28, 2005. Dr. Petrie had the treatment goal of reducing Ms. Asare’s pain by 50% and increasing her range of motion and function within two weeks; and getting her in condition to return her to work within four to eight weeks. On December 28, 2005, he pronounced Ms. Asare had reached maximum end-benefit with chiropractic treatment and released from active care in his office. He advised her that her injuries had significantly resolved to continue with the massage therapy and physical therapy.

 These courses of treatment all predated Ms. Asare’s October 6, 2006 termination hearing and subsequent termination for failing to return to work.

 I find that the panel did not employ an erroneous medical standard. The Board is bound by the panel’s conclusion because a majority of the physicians on the panel responded in the negative to question one. Since the Panel did not employ an erroneous medical standard, neither DALA nor CRAB has the authority to overturn its decision. *Malden Retirement Bd. v. Contributory Retirement Appeal Bd*.

From the record, it appears that Ms. Asare simply did not want to return to work and utilized many medical providers in her effort. She appeared for evaluations without the MRI studies crucial for an accurate diagnosis. Dr. Petrie attributed Ms. Asare’s reluctance to “fear avoidance” of injury if she were to return to work.

 For the foregoing reasons, Ms. Asare has not proven that the regional medical panel employed an erroneous medical standard or lacked pertinent facts in arriving at its conclusion.

Accordingly, the Taunton Retirement Board’s denial of Ms. Asare’s application for accidental disability retirement is affirmed.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Angela McConney Scheepers

Administrative Magistrate

DATED:

1. Disease of the spinal nerve root. *Stedman’s Medical Dictionary*, (28th ed. 2006.) [↑](#footnote-ref-1)
2. A graphic representation of the electric currents associated with muscular action. *Stedman’s Medical Dictionary*, (28th ed. 2006.) [↑](#footnote-ref-2)