COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. **Division of Administrative Law Appeals**

**Michael Lanni,**

Petitioner

v. Docket No. CR-15-116

Date Issued: August 19, 2016

**Everett Retirement Board,**

Respondent

**Appearance for Petitioner:**

Daniel C. Finbury, Esq.

Finbury & Sullivan, P.C.

55 Ginty Boulevard

Haverhill, MA 01830-6124

**Appearance for Respondents:**

Nicholas Poser, Esq.

Law Office of Nicholas Poser

197 Portland Street, 5th Floor

Boston, MA 02114

**Administrative Magistrate**

James P. Rooney

**Summary of Decision**

Denial of accidental disability application based on a regional medical panel’s finding is reversed and remanded. The panel majority erroneously determined that the applicant was not permanently disabled to a “medical certainty.” On remand, a new panel is to consider whether his disability is likely to be permanent.

**DECISION**

Petitioner Michael Lanni appealed timely, under M.G.L. c. 32, § 16(4), the February 25, 2015 decision of the Respondent, Everett Retirement Board, denying his request to receive accidental disability retirement benefits. The Board based its decision on the conclusion of a regional medical panel that examined Mr. Lanni. One member of the panel thought Mr. Lanni was not disabled; the other two panel members thought he was disabled, but could not say to a “medical certainty” whether he was permanently disabled.

I held a hearing on June 8, 2016 at the Division of Administrative Law Appeals, One Congress Street, Boston, Massachusetts. I recorded the hearing digitally. I admitted twenty-three documents into evidence – 18 from Mr. Lanni and 5 from the Board. I marked Mr. Lanni’s prehearing memorandum as Pleading A[[1]](#footnote-1) and the Board’s prehearing memorandum as Pleading B. Mr. Lanni testified on his own behalf; the Board called no witnesses. The administrative record closed after the parties made their final oral arguments.

**FINDINGS OF FACT**

Based on the testimony and evidence presented by the parties, and reasonable inferences from them, I make the following findings of fact:

1. Michael Lanni, who was born in 1968, worked as a custodian in the Everett schools for five years, beginning in 2007. His job involved heavy physical labor, including mopping, cleaning, lifting heavy buckets of mop water, snow blowing, and climbing ladders. (Lanni Testimony; Board Ex. A.)

2. In 2012, Mr. Lanni was assigned to the Lafayette School, an elementary school. On February 3, 2012, he was injured while cleaning a flooded bathroom. He slipped in two to three inches of water on the bathroom floor and fell down, hitting his head and his right side. He instantly felt pain in his right arm and had difficulty lifting himself off the floor. (Lanni Testimony.)

3. Mr. Lanni was taken that day to the Whidden Memorial Hospital emergency room. The initial diagnosis was a “deep bruise (contusion)” of his elbow. He was told that he might expect to have pain and swelling for a few weeks. (Lanni Ex. 1.)

4. Mr. Lanni continued to have pain ten days later. An x-ray of his right elbow on February 13, 2012 did not show a fracture or a dislocation. (Lanni Exs. 2 and 3.)

5. By the end of February 2012, when Mr. Lanni’s pain had still not abated, his primary care physician, Patrick Barbier, M.D., referred him to an orthopedic surgeon, Robert Davis, M.D., of Beth Israel Deaconess Medical Center. Dr. Davis ordered an MRI of Mr. Lanni’s elbow. (Lanni Ex. 5.)

6. The MRI of Mr. Lanni’s right elbow taken on April 28, 2012 showed a “high-grade partial tear of the common extensor origin” and a “[n]ear complete tear of the biceps tendon insertion.” (Lanni Ex. 5.) Dr. Davis’s plan was to “return him to physical therapy,” but with the likelihood that he would require surgery. *Id*.

7. Mr. Lanni was laid off prior to elbow surgery because he had not returned to work. (Lanni Testimony.)

8. On July 12, 2012, Mr. Lanni underwent surgery to repair the torn biceps and tendon. Thereafter, Dr. Davis sent him for more physical therapy. (Lanni Ex. 5.) Mr. Lanni underwent aquatic therapy that autumn at Whittier Rehabilitation Hospital, but reported continued high pain levels and impaired grip strength. (Lanni Ex. 7.)

9. Mr. Lanni was reexamined by Dr. Davis on January 15, 2013. He complained of right elbow, forearm, and shoulder pain. Dr. Davis noted “residual inflammation of his biceps tendon repair.” He asked Mr. Lanni to consider more physical therapy or an evaluation by a pain clinic for “complex regional pain syndrome.”[[2]](#footnote-2) (Lanni Ex. 5.) Dr. Davis saw Mr. Lanni again on April 26, 2013. Mr. Lanni reported difficulty with physical therapy because of shoulder pain. Dr. Davis recommended further physical therapy, particularly range of motion exercises. *Id*.

10. Mr. Lanni was evaluated on July 9, 2013 by Fernando Mujica, M.D., of the Arnold Pain Management Center. Dr. Mujica recommended “aggressive PT/OT” because this will “help him regain his mobility in his arm/hand as there does not seem to be any neurologic injury.” He did not find that Mr. Lanni had any “signs/symptoms consistent with CRPS [complex regional pain syndrome].” (Lanni Ex. 5.)

11. Mr. Lanni filed an application for accidental disability retirement on August 20, 2013 due to “chronic intractable pain, loss of strength and flexibility in right arm” that remained post-surgery. (Board Ex. A.) Dr. Barbier filed a physician’s statement in support of the application. He declared that Mr. Lanni had “not been able to use his [right] upper extremity as before” the 2012 accident and that his condition had plateaued. (Board Ex. B.)

12. Mr. Lanni was evaluated in May 2013, and again in September 2013 and in March 2015 by Richard Warnock, M.D., an orthopedic surgeon, in connection with a claim for workers’ compensation he had filed. In his report of his May 2013 evaluation, Dr. Warnock expressed puzzlement that Mr. Lanni’s pain symptoms had not improved and recommended that he be referred to a pain clinic. He thought Mr. Lanni capable of only light duty work that would require him to lift no more than five pounds. After his September 2013 evaluation, Dr. Warnock reported that his “medical opinion with a reasonable degree of certainty [was] that Mr. Lanni’s diagnosis appears causally related to the fall” in 2012, but that his “symptoms are out of proportion to the objective findings.” He also stated that he did “not think he has a classic pain syndrome by any reasonable assessment by me, but I would [again] recommend that [he] is seen by a pain clinic to determine if that is the case.” He also thought “a course of injections in his shoulder would be reasonable.” He added that Mr. Lanni “is not at a medical end result until the pain clinic has ruled on his condition.” (Lanni Ex. 8.) In his report of the 2015 evaluation, Dr. Warnock noted that the pain clinic that had evaluated Mr. Lanni -- the Arnold Pain Management Center -- did not think he had complex regional pain syndrome, but that he had later been examined by a Dr. Ross who thought he had “some degree of symptoms relative to a complex regional pain syndrome, but that he [Dr. Ross] needed additional information.” Dr. Warnock added that Dr. Ross did not give Mr. Lanni an injection in his shoulder. He concluded that Mr. Lanni’s condition had not changed and that he had reached a medical end result. *Id*.

13. Mr. Lanni was also evaluated in February 2014 by Kenneth J. Glazer, M.D., an orthopedic surgeon, in connection with his workers’ compensation claim. Based on his examination of Mr. Lanni and a review of his medical records, Dr. Glazer concluded that:

Mr. Lanni has reached an end result from his right elbow injury and surgery. Regarding his right shoulder, I would be hesitant to proceed with any surgical treatment seeing how poorly he has done with his elbow. Consideration could be given to a cortisone injection for the shoulder but I would be concerned about any more invasive type of treatment. I do feel that his best course of treatment would be further involvement with a pain management program that could address all of his pain issues.

(Lanni Ex. 12.)

14. A medical panel was convened in August 2014. The panel originally included Dr. Ross, but because he had already treated Mr. Lanni, he was replaced in January 2015. The final medical panel consisted of two orthopedic surgeons, Louis A. Bley, M.D., and Steven H. Sewall, M.D., and a neurologist, Judy Fine-Edelstein, M.D. Drs. Bley and Fine-Edelstein thought that Mr. Lanni was disabled and that the disability might be the natural and proximate result of his arm injury, but could not say that this disability was permanent. Dr. Sewall concluded that Mr. Lanni was not disabled. (Board Ex. D; Lanni Exs. 13 and 14.)

15. Drs. Bley and Fine-Edelstein reviewed Mr. Lanni’s 2012 and 2013 medical records and examined Mr. Lanni on August 22, 2014. Mr. Lanni reported chronic elbow pain that “radiates down the arm into his fingers” and “occasionally . . . radiates up into his shoulder.” He also told the doctors that a Lidoderm patch he has been using provided only mild pain relief. The doctors noted he has a decreased range of motion in his right elbow and pain to touch in in his right hand and arm. They concluded that:

[I]t is our medical opinion that [Mr. Lanni] sustained a tear to the right biceps tendon, and a surgical procedure to repair the tear, and to excise the extensor tendon and debride. He continued to have significant pain and discomfort, and appears to have some symptoms which may be consistent with chronic pain syndrome, given the hyperestesia,[[3]](#footnote-3) feeling of swelling, temperature change, and severe burning and chronic pain, some decreased range of motion, mild weakness, and poor response to usual therapies.

The medical panel feels that at the present time the symptoms that Mr. Lanni has are significant, and would prohibit him from working in his occupation as a custodian. We cannot state with medical certainty at this point whether he has reached maximum medical improvement, and whether his symptoms are clearly permanent, as although we do not have medical notes, there is an ongoing evaluation for continued shoulder pain, as well as an evaluation that may include a bone scan, and other treatment for possible chronic regional pain syndrome, which may include a sympathetic block.[[4]](#footnote-4) For this reason, although the injury and symptoms are causally related to this work, and at present he is disabled from his occupation, it is not clear that he has reached full maximum medical improvement, as there are continuing medical evaluations underway at this time.

(Bd. Ex. D; Lanni Ex. 13.)

16. Dr. Sewall evaluated Mr. Lanni on October 27, 2014. He noted that “some mild atrophy of the musculature” of Mr. Lanni’s right arm, but little diminution in the range of motion of his right elbow. He made no mention of any pain Mr. Lanni experienced in his right elbow or arm. He concluded that Mr. Lanni:

is post-surgery for lateral epicondylitis and tear of the common extensor tendon to the right hand as well as tear of the biceps as it inserts into the elbow, but I think he has a good surgical result. Incidentally, he has good strength in testing elbow flexion against resistance, and compared to the wrist.

I do not feel he is a candidate for disability.

I do feel he is capable of returning to his regular work as a custodian.

(Bd. Ex. D; Lanni Ex. 14.)

17. On February 27, 2015, the Everett Retirement Board denied Mr. Lanni’s accidental disability application based on the medical panel’s reports. (Bd. Ex. E.) Mr. Lanni appealed timely on March 5, 2015. (Lanni Ex. 18.)

18. Mr. Lanni was evaluated on in July 2015 by Frank Graf, M.D., an orthopedic surgeon, in connection with his workers’ compensation claim. Dr. Graf thought he was medically disabled and the disability was “total and likely to be permanent.” He also concluded that:

A medical end result probably has been reached. However, there has not been an MRI of the cervical spine and this is appropriate and is likely to explain the intractability of his current symptoms and the limited success of surgery directed to the elbow.

(Lanni Ex. 15.)

19. Mr. Lanni last saw his surgeon, Dr. Davis, in June 2015. Dr. Davis did not recommend any additional surgery or order a bone scan. He thought Mr. Lanni’s condition had plateaued and recommended only exercise. Mr. Lanni has a home exercise program he performs that mostly involves stretching. He continues to have pain in his right arm every day; he experiences shooting pain on the inside of his elbow as well as a pins and needles sensation. He describes the typical pain level as 4 or 5 on a ten point scale. He can grip objects with his right hand, but he cannot hold them for long because of the pain, and as a result he has dropped items he was holding. He cannot sleep through the night. (Lanni testimony.)

**DISCUSSION**

In order to receive accidental retirement disability benefits, an applicant must establish by substantial evidence that he is totally and permanently incapacitated from performing the essential duties of his or her position as a result of an injury sustained or hazard undergone while in the performance of his duties. M.G.L. c. 32 § 7; *Donnelly v. State Bd. of Retirement*, Docket No. CR-08-312 (Mass. Div. of Admin. Law App., Aug. 26, 2010). No application may be approved until the applicant has been examined by a medical panel whose function is to determine medical questions that are beyond the common knowledge and experience of a local retirement board.  *Malden Retirement Bd. v. Contributory Retirement App. Bd.*, 1 Mass. App. 420, 423, 298 N.E. 2d 902, 904 (1973). Unless the medical panel has applied an erroneous standard or failed to follow the proper procedures, or unless the certificate is “plainly wrong,” a retirement board may not ignore the panel’s medical findings. *Id*. at 424, 298 N.E.2d at 905; *Kelley v.* *Contributory Retirement App. Bd.*, 341 Mass. 611, 617,171 N.E. 2d 277, 281 (1961).

In this instance, Drs. Bley and Fine-Edelstein, who made up a majority of the medical panel, thought that Mr. Lanni was disabled from performing the essential duties of his job and that his disability was caused by the injury he sustained in 2012 while working, but could not say that his disability is permanent. (Finding 15.) The other panelist, Dr. Sewall, did not think Mr. Lanni was even disabled. (Finding 16.)

The medical panel majority applied an erroneous standard in responding to the issue of permanence. Dr. Sewall applied an erroneous standard with respect to disability.

While there is no definition for the term “permanent” or standard for the determination of permanency in either the public employee retirement statute, M.G.L. c. 32, or in the workers’ compensation statute, M.G.L. c. 152, the Contributory Retirement Appeals Board (CRAB) and the Division of Administrative Law Appeals (DALA) have generally adopted the “likelihood of permanence” standard used in insurance cases to distinguish permanent from temporary disability.[[5]](#footnote-5) *Antonellis v. Essex Regional Ret. Bd*., Docket No. CR-03-392 (Mass. Div. of Admin. Law App., Sept. 11, 2003; CRAB, Feb. 23, 2004)

In *Yoffa v. Metropolitan Life Insurance Company*, 304 Mass.110, 111-112, 23 N.E.2d 108, 109 (1939), the Supreme Judicial Court concluded that a disability for purposes of an insurance policy is considered to be permanent if it is shown to be of such a character that, based on the evidence at the time of the determination, is likely to continue permanently. Three years later, the Court confirmed this approach in *Hovhanesian v. New York Life Insurance Company*, 310 Mass. 626, 628, 39 N.E.2d 423, 425 (1942), holding that total disability payments could begin once the disability “is shown to be of such a character that it is likely to continue permanently; that is to say, if it is ‘presumably’ permanent.”

The structure of Chapter 32 lends itself to the approach taken in insurance cases for defining permanency. M.G.L. c. 32, §§ 6 and 7, which address ordinary and accidental disability retirement respectively, require a member to prove only that a disability is “likely to be permanent” in order to be eligible for a disability pension. Section 8, which addresses reevaluation of members retired for disability, assumes that at least some disabilities of persons granted disability pensions will not last forever. Section 8 requires periodic reexaminations, rehabilitation programs and procedures for a return to work if a member is found to be able to perform the essential duties of his or her former position. This provision demonstrates that the legislature did not intend to delay the award of disability retirement benefits until there is absolute certainty that a disability is permanent. *See Rego v. State Bd. of Retirement*, Docket No. CR-98-521 (Mass. Div. of Admin. Law App., Sept. 8, 1999). It also implies that the level of proof a finder of fact should require regarding permanency of a disability is not certainty. Thus, a petitioner has the burden of proving only that his disability is likely to be permanent, not that it is certain to be permanent. See id.

Based on this analysis, CRAB concluded that, for purposes of Chapter 32, a disability shall be considered to be permanent:

if it is shown to be of such a character that it is more likely than not to continue permanently even though recovery at some remote of unknown time is possible. In making this determination, the fact finder, in this case the medical panel, shall consider (a) the period of time that the disability has continued; (b) the nature of the disability and whether it appears, based on all of the then available evidence, to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period; and (c) the likely effect of a return to the essential duties of the member's position on the recovery. If recovery can reasonably be expected after a fairly definite time, and is not likely to be reversed by the member's performance of the normal essential duties of his or her position, the disability cannot be classed as permanent.

*Antonellis*, CRAB decision at 5.

In this case, the medical panel majority declined to conclude that Mr. Lanni’s injury was permanent because there was an “ongoing evaluation” of the source of his pain, the cause of which had so far eluded his doctors. The panelists stated:

We cannot state with medical certainty at this point whether he has reached maximum medical improvement, and whether his symptoms are clearly permanent, as although we do not have medical notes, there is an ongoing evaluation for continued shoulder pain, as well as an evaluation that may include a bone scan, and other treatment for possible chronic regional pain syndrome, which may include a sympathetic block.

(Finding 15.)

Exactly what the panelists were referring to is not entirely clear, particularly in light of their statement that they lacked medical notes. Mr. Lanni’s surgeon, Dr. Davis, had not recommended a bone scan, as far as the records indicate, and Mr. Lanni has not had a bone scan since. Mr. Lanni had been evaluated prior to the time he saw the medical panelists to see if he suffered from complex regional pain syndrome. The Arnold Pain Management Center concluded that he did not exhibit symptoms of this syndrome, while Dr. Ross thought he had some symptoms consistent with it, but that more information was needed to make a definitive diagnosis. There is nothing evident in the record suggesting that his doctors were considering a sympathetic block to numb the pain in the affected nerves. But even though the medical panelists’ source for their view of potential future treatment approaches for Mr. Lanni is unclear, it doubtless was worthwhile at the time and is still worthwhile for Mr. Lanni’s doctors to attempt to determine why he still has disabling arm and elbow pain after his surgery and to propose a treatment plan that will provide him some relief.[[6]](#footnote-6) That effort, however, should not have prevented the medical panelists from determining whether Mr. Lanni’s disability is permanent. As pointed out above, the issue is not whether Mr. Lanni’s injuries are “clearly permanent,” but whether they are likely to be permanent, which they would be even if recovery might be possible at some unknown, remote time in the future. When the medical panel evaluated Mr. Lanni, his post-surgical pain and discomfort had lasted more than two years, with little or no improvement. The medical panelists did not opine that he was likely to recover in some definite time. Instead, they hypothesized that further evaluations might lead to a helpful treatment. This possibility should not have prevented the panelists from rendering an opinion as to whether Mr. Lanni’s disability was likely to be permanent. Their failure to do so was error.

The third member of the medical panel, Dr. Sewall, thought that Mr. Lanni was not disabled because his surgery had repaired his torn biceps and tendon and because he had good grip strength with his right hand. (Finding 16.) This conclusion is erroneous because the issue in this case is not whether Mr. Lanni’s arm is still physically damaged from his 2012 injury. In his disability retirement application, Mr. Lanni stated that the reason for filing the application was “chronic intractable pain.” (Finding 11.) Dr. Sewall did not discuss whether Mr. Lanni’s pain was disabling. His conclusion is therefore erroneous because he did not address the issue of persistent, disabling pain.

Even though the medical panel did not apply the proper standard, it is not generally for DALA to make a medical determination of that a disability is permanent. *See Malden Retirement Bd.*, 1 Mass. App. Ct. at 424, 420, 298 N.E.2d at 905. Only when it is clear that if the panel applied the correct standard, it would have found the disability to be permanent, and that the applicant was disabled and the disability was the result of an injury sustained or hazard undergone while in the performance of his duties, may DALA conclude that a flawed medical panel certificate meets sufficiently the general requirement that an application be supported by an affirmative medical panel certificate. *Antonellis*, CRAB decision at 7.

There is some evidence in the record that Mr. Lanni’s disability is likely to be permanent. Drs. Barbier and Glazer concluded that Mr. Lanni has reached an end medical result. Dr. Warnock thought so too, so long as Mr. Lanni does not have complex regional pain syndrome. Still, it is not clear that the medical panel would necessarily have answered “yes” to the question as to permanency if it had applied the proper standard.

Accordingly, the decision of the Everett Retirement Board denying Mr. Lanni’s accidental disability retirement application is reversed, and the matter is remanded to the Board for resubmission to a medical panel. Given the length of time since the panel’s evaluation of Mr. Lanni, submission to a new panel would be warranted.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

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

James P. Rooney

First Administrative Magistrate

Dated: August 19, 2016

1. The Board initially moved to strike Mr. Lanni’s prehearing memorandum because his counsel failed to attach his proposed exhibits and to send an electronic version of the memorandum to Board counsel. Mr. Lanni’s counsel later corrected these defects. Therefore, the Board’s motion to strike is denied. [↑](#footnote-ref-1)
2. Complex regional pain syndrome “is an uncommon form of chronic pain that usually affects an arm or a leg. Complex regional pain syndrome typically develops after an injury, surgery, stroke or heart attack, but the pain is out of proportion to the severity of the initial injury. The cause of complex regional pain syndrome [is not] clearly understood.” http://www.mayoclinic.org/diseases-conditions/complex-regional-pain-syndrome/basics/definition/con-20022844. [↑](#footnote-ref-2)
3. Hyperesthesia is “an increased sensitivity to the stimuli.” http://medicalopedia.org/2462/hyperesthesia-causes-diagnosis-and-treatment/. [↑](#footnote-ref-3)
4. Complex regional pain syndrome is sometimes treated with an “[i]njection of an anesthetic to block pain fibers in [the] affected nerves.” http://www.mayoclinic.org/diseases-conditions/complex-regional-pain-syndrome/basics/treatment/con-20022844. [↑](#footnote-ref-4)
5. This approach is consistent with decisions in other jurisdictions in which the question of what constitutes a permanent versus a temporary disability has been presented. *See Cunningham v. Com. Pennsylvania State Police*, 510 Pa. 74, 82-83, 507 A.2d 40, 44-45; *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Rose v. Thornton and Florence Electric Company*, 4 Kan.App.2d 669, 609 P.2d 1180 (1980); *Overland Construction v. Industrial Commission*, 37 Ill.2d 525, 229 N.E.2d 500 (1967); and *Logsdon v. Industrial Commission*, 143 Ohio St. 508, 57 N.E.2d 75 (1944). [↑](#footnote-ref-5)
6. Board counsel noted Dr. Graf’s opinion that an MRI of Mr. Lanni’s cervical spine might be valuable and could help explain his continued pain. Dr. Graf, like most of the other doctors who has evaluated Mr. Lanni, is an orthopedic surgeon. Counsel suggested that an evaluation by a neurologist would be appropriate. [↑](#footnote-ref-6)