THE COMMONWEALTH OF MASSACHUSETTS
CONTRIBUTORY RETIREMENT APPEAL BOARD
OFFICE OF THE ATTORNEY GENERAL
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January 8, 2020

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Re: Robert Hollup v. Worcester Retirement Bd., CR-15-221.

Dear Counsel:

Enclosed please find the Decision of the Contributory Retirement Appeal Board. Any party aggrieved by the Decision may, within thirty (30) days of receipt of this notice and the enclosed decision, appeal to the Superior Court in accordance with the provisions of Massachusetts General Laws, Chapter 30A, § 14.

Very truly yours,
Uyen M Tran (db)
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UMT/db
cc: Edward McGrath, Esq. DALA/original
PERAC/Courtesy

Enclosure

COMMONWEALTH OF MASSACHUSETTS
CONTRIBUTORY RETIREMENT APPEAL BOARD

ROBERT HOLLUP,

Petitioner-Appellee

v.

WORCESTER RETIREMENT BOARD,

Respondent-Appellant

CR-15-221

DECISION

Respondent Worcester Retirement Board (WRB) appeals from a decision of an administrative magistrate of the Division of Administrative Law Appeals (DALA), reversing the WRB's decision that denied the petitioner Robert Hollup's third application for accidental disability retirement benefits. The DALA magistrate heard the matter on February 11, 2016 and admitted forty exhibits. The magistrate's decision is dated November 2, 2016. The WRB filed a timely appeal to us.

We note that Hollup filed two previous applications for accidental disability retirement benefits based on the same incident involving a fall from, or as he was stepping off, a garbage truck. The first application, citing disability from closed head trauma, concussive syndrome, and a herniated disc, resulted in a negative certification by a regional medical panel composed of two neurologists and a specialist in internal medicine. This regional medical panel concluded that the petitioner did not have a neurological disability, but stated it was beyond the scope of their evaluation to comment on worsening psychiatric dysfunction.[1] The first application was denied, and Hollup took no appeal.[2] The second application cited no medical

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[1] Findings of Fact 39, 54.

[2] Finding 58.

condition and contained the same Treating Physician Statement submitted with the first application. After unsuccessfully seeking an updated Treating Physician Statement, the WRB notified Hollup it was taking no action on the second application. Hollup did not appeal from the failure to act.[3] Subsequently, Hollup submitted a third application based on a psychiatric disability ("depression caused by head injury"). He received a unanimous positive medical panel certification on this third application. Since this third application for accidental disability retirement has a different medical condition from the first application, it was not barred by the earlier denial of his first application.[4]

Regarding the report of the first regional medical panel, we do not agree with the WRB that this report, concluding there was insufficient objective evidence for Hollup's continued headaches and dizziness, should have been provided to the later psychiatric medical panel. The psychiatric panel physicians had access to the medical history and were able to form their own opinions as to the significance of Hollup's brain computerized tomography (CT) and magnetic resonance imaging (MRI) scans, which showed no swelling or intracranial bleeding following his head injury. PERAC regulations instruct that reports of prior medical panels are not to be given to a subsequent panel. [5] This rule helps assure that the panel's decision will not be unduly influenced by earlier panel reports. The second panel focused on Hollup's psychiatric condition. Their conclusions were not bound by the earlier panel's rejection of Hollup's claim based on a neurological injury.

There is also no preclusive effect of an unreported Appeals Court decision that affirmed a decision of the Department of Industrial Accidents (DIA) denying continued

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[3] Findings 57, 60, 63.

[4] *See generally* Restatement (Second) of Judgments § 83 (1982) (claim preclusion requires identity of cause of action); *cf. McLaughlin v. City of Lowell*, 84 Mass. App. Ct. 45, 56 (2013) (preclusive effect of administrative decisions). The lack of an appeal from the WRB's failure to act also does not act as a bar to the later application, since nonaction is not binding, and in any event no medical condition was cited. *See generally Barnstable County Retirement Bd. v. Public Employee Retirement Admin. Comm'n*, CR-07 0163 (CRAB Feb. 17, 2012).

[5] *See* 840 C.M.R. § 10.01(7) which provides:

> The medical panel shall not be provided with copies of the certificates and narratives of medical panels which previously examined the member or with copies of decisions by the Division of Administrative Law Appeals or the Contributory Retirement Appeal Board involving the member.

workers' compensation benefits to Hollup.[6] Both the DIA reviewing board and the Appeals Court apply highly deferential standards on review of a DIA administrative judge's decision.[7] The affirmance by the Appeals Court merely represents a conclusion that the DIA board did not abuse its discretion in concluding that the administrative judge's decision was not "beyond the scope of his authority, arbitrary or capricious, or contrary to law."[8] The Appeals Court decision does not make the administrative judge's findings or rulings binding on the DALA magistrate, who makes her own findings of fact based on the evidence submitted.[9]

Summary

After considering all the arguments presented by both parties and after review of the record, we adopt the magistrate's Findings of Fact 1-71 as our own, with changes as noted.[10] Because we do not agree that Hollup has proven by a preponderance of the evidence that his

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[6] *See Hollup's Case*, 79 Mass. App. Ct. 1124 at *1-2 (2011).

[7] *See* G.L. c. 152, §§ 11C, 12(2); G.L. c. 30A, § 14(7)(a)-(d), (f)-(g).

[8] G.L. c. 152, § 11C; *cf. Wilson's Case*, 89 Mass. App. Ct. 398, 400-401 (2016) (noting that, at least where a finding of fact is reversed by the DIA, this doubly deferential standard of review requires the Appeals Court to consider "whether the board was arbitrary and capricious in concluding that the administrative judge was arbitrary and capricious") (citation omitted).

[9] *See Soucy v. Contributory Retirement Appeal Bd.*, 69 Mass. App. Ct. 558, 565 (2007) (DIA administrative judge's determination not binding on retirement board or DALA magistrate).

[10] In Finding 3 we change the last sentence to read: "He reported that he fell backwards into a brick retaining wall and hit the back of his head." Exhibit 27.

In Finding 5 we add a second sentence: "He denied nausea, vomiting, or dizziness (the report reads, "no N/V/dizziness"). We change the following sentence to read: "He had a 2-centimeter laceration on the back of his head that was sutured with six (6) staples." Ex. 27.

In Finding 8 we change the third sentence to read: "In addition to headaches and dizziness he complained of back pain and blurred vision." Ex. 27.

In Finding 12 we delete the words: ", although the nausea and vomiting had abated." Ex. 20.

In Finding 13, we delete the fifth sentence and add in its place: "Dr. Venema's report stated that, when the Petitioner was seen on September 18, 2004, he complained of symptoms including vomiting. The source of this information is unclear because the treatment record of September 18 made no mention of vomiting, and the emergency department record stated there had been no vomiting. (Exhibits 27, 20, 11, 22.) Dr. Venema further reported that since September 2004, the Petitioner's symptoms of nausea 'and vomiting' had resolved and the dizziness had waned."

In Finding 22, we change the fifth sentence to read, "The Petitioner reported that he hit the back of his head and was "knocked down unconscious."

psychiatric condition was proximately caused by his September 14, 2004 head injury, we reverse.

Background

1. *The September 14, 2004 head injury.*

Hollup worked as a laborer and motor equipment operator for the City of Worcester from January 21, 2003 until September 14, 2004.[11] His assignment was as a garbage "picker" – he would ride on the outside of a garbage truck, jump down, pick up garbage bags, and place them in the truck. On September 14, 2004, he stepped down from the truck into a rut or pothole and lost his balance. He fell backwards, hitting the upper left side of the back of his head on a brick retaining wall. His head began to bleed, and bystanders called an ambulance, which transported him to UMass Memorial Medical Center (UMMC). At the emergency department (ED), a two-centimeter (just under one-inch) laceration was closed with six staples.[12] Hollup complained of a headache and lower back pain. He reported no loss of consciousness, no neck pain, and no nausea, vomiting, or dizziness. His Glasgow coma scale was normal. X-rays of his back showed degenerative changes, but no acute injury. Hollup received two Vicodin in the ED and was given a prescription for thirty (30) more Vicodin.[13]

Four days later, on September 18, 2004, Hollup returned to the ED, complaining of headache, light-headedness, blurred vision, and nausea. He was diagnosed with post-concussive headache. A CT scan of Hollup's head was normal, ruling out intraparenchymal bleeding, fracture, hydrocephalus, or other abnormalities. Hollup stated that he had accidentally thrown out his Vicodin and was given another prescription for Vicodin.[14]

Three days later, on September 21, 2004, Hollup apparently returned to UMMC, complaining of pain. Although the ED record reported that Hollup had no loss of

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[11] Exs. 3, 5; Finding 1. Hollup had previous employment with the city as a library custodian, apparently from approximately 1998-2002 (Exs. 11, 17, 28). He also had a second job as a truck driver for an ice company. Previously, he worked as a certified nurse's assistant, assembler of motor vehicles, oil change technician, and bouncer. (Exs. 11, 28, 35).

[12] Ex. 27. Hollup later reported that he had received eight staples, and the error was repeated. *See* Exs. 14, 5, 22, 36, 38. We do not view the difference as significant.

[13] Exs. 5, 6, 11, 14, 27; Findings 3-5.

[14] Ex. 27; Finding 7.

consciousness, he told a Dr. Li that he had lost consciousness after his fall.[15] Dr. Li gave Hollup another prescription for twenty Vicodin to manage his pain.[16]

For approximately a year and a half before his fall, Hollup had been taking Vicodin for back pain.[17] He also received Vicodin prescriptions during each of the five preceding months: in April, May, and June 2004 (after another work fall resulting in broken ribs), in July 2004 (for knee pain), and in August 2004 (after a fight at work in which he was pushed through a glass window and received sutures in his arm). His record for the August 2004 incident noted a past diagnosis of drug abuse.[18]

On September 23, 2004, nine days after his fall, Hollup saw his primary care physician, Morris M. Milman, M.D., for continued headache and back pain. Dr. Milman noted that the back pain, which predated Hollup's fall, was not work-related. He removed the sutures in Hollup's scalp and gave him another prescription for Vicodin.[19] Based on Hollup's complaints of continued headache, dizziness, nausea, and blurred vision, Dr. Milman referred him to a neurologist.[20]

While awaiting the neurology appointment, Hollup again saw Dr. Milman on October 5, 2004, seeking a note to be excused from work and complaining of headache. Dr. Milman

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[15] Whether because this assertion was repeated by Hollup, or because each physician referred back to the prior record, the statement that Hollup lost consciousness appears in nearly every subsequent medical record. *E.g.*, Exs. 4, 6, 7, 11, 15, 19, 20, 22, 23, 24, 25, 27, 28, 31, 35, 36, 37, 39; *contra*, Ex. 34. None of these records mentions or discusses the original ED record that stated there was no loss of consciousness. A reviewer in 2013 noted that the ED report was missing from the medical records available for review at that time. Ex. 17.

[16] *See* Ex. 11 (decision of DIA Administrative Judge Paul F. Benoit, citing report by psychiatrist Dr. Michael Rater dated August 7, 2009).

[17] Exs. 6, 20, 17 at 3.

[18] Exs. 27, 11, 17; *see* Exs. 27 (7/14/08), 29, 20 (6/28/06), 35, 11. We clarify that, although the record is replete with evidence of long-term use of prescription opioids, with some note of minor withdrawal symptoms (Ex. 20, 06/28/2006) there is no suggestion that Hollup was using opioids other than those prescribed.

[19] Ex. 27. Hollup also apparently told Dr. Milman that he had lost consciousness after his fall, and Dr. Milman so stated in his note. Ex. 27 (9/23/04). The note does not mention the ED record indicating no loss of consciousness.

[20] Ex. 27.

advised Hollup to take Vicodin with Tramadol as needed pending his neurology appointment.[21]

2. *Neurological treatment and continued use of pain medication.*

The initial concern after Hollup's fall was that he had post-concussive symptoms, primarily headaches and dizziness. Hollup reported these symptoms for many years, and was followed and treated by two neurologists. He also continued to receive opioid medications for back and head pain, often with warnings about the potential for medication overuse headaches and opioid dependence.

On October 15, 2004, Hollup was seen by neurologist James R. Venema, M.D. He reported continued headaches, cognitive issues, and irritability, but lessened dizziness. Dr. Venema found no orthostatic hypotension that would explain the reported dizziness upon standing up from a supine position. He suspected that the dizziness might be a side effect of Tramadol and advised Hollup to taper off Tramadol and ibuprofen, avoid Vicodin for headache, and start Depakote. Dr. Venema opined that Hollup's headaches could be either post-concussive or a result of medication overuse. He ordered an MRI and an MRA[22] and provided Hollup with a note excusing him from work pending the results.[23]
The MRI and MRA were obtained on October 27, 2004 and were normal.

Subsequently, on November 23, 2004, Hollup attended an impartial medical examination (IME) with Lalit Savla, M.D., a neurologist. The doctor concluded his headaches were likely due to muscle contractions and medication overuse. He cleared Hollup to return to work "in full capacity."[24]

In early January 2005, Hollup called Dr. Venema four times, seeking a continued excuse from work due to concerns with occasional headaches and intermittent dizziness. He

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[21] *Id.*

[22] Magnetic resonance imaging; magnetic resonance angiography.

[23] Ex. 22. Dr. Vydrin also wrote that Hollup had complained of vomiting when he returned to the ED on September 18, 2004. This was incorrect: no vomiting was mentioned on September 18, and the ED record from September 14 stated there had been no vomiting. Ex. 27. As with the repeated notes concerning loss of consciousness, the erroneous assertion of vomiting was repeated in several later medical reports. *See* Exs. 34, 36, 37.

[24] Ex. 23; *see also* Ex. 31 (2006 IME Dr. Levine finds muscle tension in occipital and temporalis regions); Ex. 6 (2008 neurology medical panel concludes muscle tension headaches).

felt that he was disabled by his symptoms. On January 13, 2005, Dr. Venema wrote that he had declined to provide a work excuse because Hollup's neurological testing was normal. He was unable to perform a re-assessment of his physical examination, as he failed to attend his scheduled appointment. He advised Hollup to have his employer perform a disability evaluation to determine whether his subjective complaints warranted his continued absence. Dr. Venema wrote that his headaches could be related to either Concerta or post-concussive syndrome. At Hollup's request, he scheduled him to see a headache specialist, Mikhail Vydrin, M.D., a neurologist.[25]

The next day, while awaiting his next neurology appointment, Hollup visited his primary care physician, Dr. Milman, still seeking an excuse from work. He reported that his headaches were continuing and that he was fearful of getting dizzy while riding the garbage truck. Like Dr. Venema, Dr. Milman could find no orthostatic abnormality that would cause dizziness or balance issues. Dr. Milman suggested that Hollup be evaluated by an independent worker's compensation physician to assess his ability to work.[26] Despite noting that his exam "d[id] not show any deficits," Dr. Milman gave Hollup a note excusing him from work.[27]

On February 2, 2005, Hollup asked his psychiatrist, Eric G. Smith, M.D., for a prescription for opioids or Valium to help him relax. Dr. Smith denied the request.[28]

On March 2, 2005, Hollup saw the headache specialist, Dr. Vydrin. He reported symptoms of continued headache, dizziness, forgetfulness, concentration issues, and some unsteadiness. Dr. Vydrin's examination found no problems with Hollup's coordination, stance, or fine motor control, though his movements were "rather slow." His impression was that Hollup had occipital neuralgia headaches, which were not well controlled by the Depakote, as well as post-concussive syndrome, ADHD, and mild dystonia. He began tapering Hollup off the Depakote and added Trileptal, another anticonvulsant that he thought might work better than Depakote. Hollup was also continuing to take Vicodin, "[m]ainly for

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[25] Ex. 22.

[26] It is not clear whether Dr. Milman was aware of the November IME report by Dr. Savla clearing Hollup for work, Ex. 23.

[27] Ex. 27.

[28] Ex. 20.

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[27] Ex. 27.

[28] Ex. 20.

his back pain."[29] Dr. Vydrin gave Hollup another work excuse, stating he expected Hollup could return to work after six to eight weeks.[30]

On April 26, 2005, Hollup returned to Dr. Vydrin and reported that his headaches had not improved with Trileptal and Tramadol. Dr. Vydrin reduced those medications and began Gabapentin (Neurontin, another anticonvulsant). He also ordered a cervical MRI to rule out nerve root compression, which was performed on May 3, 2005 with negative results.[31] Dr. Vydrin extended Hollup's work excuse for three to four months.[32]

An IME performed by James R. Lehrich, M.D., a neurologist, on May 24, 2005 concluded that Hollup could not yet return to full duty work, but that he could perform sedentary work. Hollup's prognosis was good, although Dr. Lehrich could not provide a specific time frame for return to full duty. Dr. Lehrich based his conclusion on both post-concussive headaches and back pain.[33]

On June 8, 2005, Hollup's dizziness was gone. He again complained to Dr. Vydrin that he continued to have headaches. Dr. Vydrin increased his dose of Gabapentin, added Effexor, and gave Hollup a prescription for Vicodin, with a warning not to use it more than once or twice a week.[34]

Hollup had a fall on his stairs at 3:00 a.m. on August 23, 2005 and was seen at the UMMC emergency department for a ligament strain in his knee. He was given a prescription for Percocet.[35]

On September 7, 2005, Hollup reported to Dr. Vydrin that his headaches had improved, but that his fall two (2) weeks earlier had been due to dizziness. Hollup reported that he had been careful to limit his use of Vicodin to 50 pills in two months. Dr. Vydrin continued the Gabapentin, Effexor, and Vicodin.[36]

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[29] Dr. Milman had given Hollup a prescription for Vicodin on September 23, 2004. Ex. 27. It is not clear which physician was providing the continued prescription.

[30] Ex. 24.

[31] *See* Ex. 34.

[32] Ex. 24.

[33] Ex. 25; Finding 24.

[34] Ex. 24; Finding 25.

[35] Ex. 27.

[36] Ex. 24; Finding 26.

By December 21, 2005, Hollup was taking one or two Vicodin or Percocet daily.[37]

On January 10, 2006, Hollup again reported to Dr. Vydrin that his headaches – which had improved previously – were now severe. Dr. Vydrin also noted that Hollup had "features of depression."[38] Hollup told Dr. Vydrin that the Vicodin was not working well and that he preferred Percocet. Dr. Vydrin prescribed Percocet and Topamax, warning Hollup to limit use of the Percocet.

On February 22, 2006, Hollup visited UMMC urgent care, seeking medication for back pain. He stated that his primary care physician was on vacation. Douglas L. Groves, M.D., noted that Hollup had just been prescribed Percocet the month before, and that he had a history of drug abuse. Nevertheless, he gave Hollup a prescription for 30 Vicodin.[39]

On April 14, 2006, Hollup told Dr. Vydrin he continued to have headaches, as well as lightheadedness. He also appeared depressed and anxious. Dr. Vydrin increased the Topamax and gave Hollup another prescription for Percocet. He warned Hollup to limit his use of Percocet and Tylenol due to the risks of addiction and rebound headaches.[40]

Two weeks later, on April 27, 2006, Hollup was seen by Robert A. Levine, M.D., a neurologist, for an IME. Hollup again complained of headaches, photophobia, dizziness with fear of falling, irritability, and low back pain. Although Hollup had just received a Percocet prescription, Dr. Levine wrote that Hollup was "off narcotics" and using Topamax, Seroquel, Cymbalta, and Tylenol, but that none of the medications had provided significant benefit. Dr. Levine recommended trigger point injections in areas of muscle tension at the left side and back of Hollup's head (suboccipital and temporalis regions), and an exercise program. Hollup was able to engage in some activity: he was cooking and operating a power lawn mower, but was avoiding shoveling snow due to back pain and fear of dizziness. He told Dr. Levine that he could return to work as a driver, but not as a garbage picker. Dr. Levine opined that

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[37] Ex. 20.

[38] January 2006 was also the first time that a psychiatrist concluded that Hollup's depression had progressed to the point where it was a contributing factor to his inability to work. *See* Ex. 28 (1/18/06) IME report of psychiatrist Dr. Michael Braverman); Finding 30. We discuss Hollup's psychiatric treatment in the following section.

[39] Ex. 29.

[40] Ex. 24.

Hollup was still not ready to return to full work duties, but that he could perform modified work. He estimated Hollup could return to work in ten to twelve weeks.[41]

On approximately May 24, 2006, Hollup again visited Dr. Groves at UMMC urgent care and received a prescription for 20 Vicodin, apparently for back pain.[42]

On May 31, 2006, Hollup saw his primary care physician, Dr. Milman, complaining of low back pain and seeking another prescription for Vicodin. Hollup did "not appear to be in any significant pain," and his examination for low back pain was "negative." He had received an epidural steroid injection, as well as twenty additional Vicodin, from Dr. Groves in Urgent Care within the past week for lower back pain.[43] Nevertheless, Dr. Milman noted he was giving Hollup the "benefit of the doubt" and prescribed 40 Vicodin.[44]

On June 28, 2006, Hollup asked his psychiatrist, Dr. Smith, to prescribe Vicodin for his headache, which Dr. Smith refused to do. Where it appeared Hollup may be going through "minor withdrawals" from substances, Dr. Smith suggested substance abuse treatment.[45]

As of July 2006, Dr. Smith reported that Hollup was continuing to use Percocet, prescribed by Dr. Vydrin.[46]

On September 27, 2006, Dr. Milman renewed Hollup's Vicodin prescription for low back pain.[47]

On October 4, 2006, Hollup saw Richard Anderson, M.D., a neurologist, for an IME. Dr. Anderson reviewed the history – by now two (2) years old – of Hollup's post-concussive symptoms and headache. Unlike previous reviewers, Dr. Anderson noted that Hollup denied loss of consciousness in the ED.[48] He noted that four different neurologists had found no objective evidence to explain Hollup's headaches. Dr. Anderson also found no objective

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[41] Ex. 31; Finding 33.

[42] *See* Ex. 30 (5/31/06 report of Dr. Milman).

[43] Ex. 27.

[44] Ex. 30.

[45] Ex. 20.

[46] Ex. 20 (Dr. Daniel J. Kirsch).

[47] Ex. 30.

[48] Ex. 34. Dr. Anderson also noted vomiting, which was not supported by Hollup's treatment records. Ex. 27; *see* note 14 *supra*.

evidence of back pain. He concluded that Hollup had "no physical limitations that would prevent him from returning to work without restrictions."[49] He noted, however, that Hollup had recently been hospitalized for psychiatric issues, which were being separately analyzed.[50]

From November 2006 to at least September 2007, Hollup continued to see Dr. Vydrin every two to four months, complaining of headaches. Dr. Vydrin continued to prescribe various medications, including Percocet, with warnings to limit its use. Dr. Vydrin noted that Hollup was sometimes taking Percocet four times a week to daily, and that he was taking many medications with side effects. He opined that Hollup remained disabled based on a combination of his headaches, dizziness, and psychiatric condition.[51]

On November 7, 2007, Dr. Milman renewed Hollup's prescription for Vicodin for back pain, instructing Hollup to limit his use to "one or two tablets in a day" due to the potential for addiction.[52]

Dr. Savla, a neurologist who had previously provided an IME indicating Hollup could return to work in November 2004, was hired by Hollup's attorney to provide two additional evaluations. On March 14, 2007, Dr. Savla wrote that he was aware he had written a prior report, but did not have a copy to review. Dr. Savla now opined that Hollup was not able to work in his sanitation job due to headache and mood disorder, and now opined that these symptoms were causally related to the 2004 fall. Dr. Savla reiterated this opinion on August 5, 2008.[53]

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[49] Ex. 34. Dr. Anderson did not opine as to psychiatric limitations.

[50] Hollup was hospitalized for acute depression after he was charged with domestic assault, received a restraining order, and was separated from his wife. Findings 41-42, Exs. 20, 32. The psychiatric IME was performed the same day by Michael Rater, M.D. Dr. Rater concluded that Hollup's extensive use of opiate medication, and not his head injury, was the primary cause of his mood disorders, and recommended that all opiates be stopped. He also opined that Hollup was psychiatrically able to work, although due to post-traumatic stress from his fall he should not return to riding on a garbage truck. Ex. 35. We discuss Hollup's psychiatric condition below.

[51] Ex. 24 (11/1/06, 3/6/07, 4/10/07, 6/29/07, 9/19/07); Ex. 11 (noting Dr. Vydrin prescription for Percocet on 7/25/07). Hollup told the first regional medical panel on May 15, 2008 that he took about 60 tablets of Percocet per month. Ex. 6.

[52] Ex. 30.

[53] Ex. 36; Findings 49, 56. Previously, Dr. Savla's opinion had been the same as that of the first regional medical panel – that Hollup's headaches were due to muscle tension or

Meanwhile, Hollup had filed his first application for accidental disability retirement on August 11, 2006. The application was based primarily on post-concussive symptoms, including headaches and dizziness, as well as back pain.[54] A regional medical panel consisting of two (2) neurologists, Brian Mercer, M.D., and Michele L. Masi, M.D., and an internal medicine specialist, Mark Friedman, M.D., examined Hollup on May 15, 2008. The panel physicians unanimously concluded that Hollup was not disabled from his job as a sanitation worker. Hollup's fall, as he originally described it, was less forceful than he later claimed in his application – he stepped down from the truck into a rut or pothole, lost his balance, and fell backwards into a wall. He did not fall at high speed from a fast-moving vehicle. He also did not lose consciousness. He had a normal Glasgow coma scale in the ED and no findings on CT or MRI. Neurological examinations were normal. The panel physicians concluded that this type of head injury was "not expected to produce sustained cognitive or behavioral deficits" and characterized it as "very mild." Four years after the injury, there was insufficient "objective evidence to support Mr. Hollup's subjective complaints of headache and intermittent dizziness." Hollup had "mild muscle tension headaches with a possible analgesic rebound component related to chronic narcotic use," but his symptoms no longer could be causally attributed to his fall.[55]

Hollup had been receiving Workers' Compensation benefits since the head injury. A voluntary adjustment was entered into on February 28, 2008. Subsequently, Hollup sought additional benefits commencing June 5, 2008. However, his claim was denied by

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medication overuse (i.e., not causally related to his fall) and that he was able to return to work. It is surprising that Dr. Savla did not discuss his change of opinion.

[54] Ex. 3. The application listed "closed head trauma, concussive syndrome, herniated disc L3-4." Hollup wrote that he was unable to work "[b]ecause of my headaches and dizziness, dizziness that comes and goes at any time, which could make me fall off the back of the moving truck at any time, plus my back injury."

[55] Ex. 6; Finding 54. This opinion echoed that of the first IME performed by Dr. Lalit Savla in November 2004, two months after Hollup's injury. Ex. 23.

The panel also concluded that Hollup's back symptoms "would not prevent him from performing the physical aspects of sanitation work." Physical examination showed no evidence of lumbosacral radiculopathy, and the imaging studies showed only mild degenerative changes. Prior to the fall, he had been taking medication for back pain for a year and a half, and had still been able to work. Moreover, Hollup "denied current significant lumbar symptoms." Ex. 6.

Administrative Judge Paul F. Benoit in a hearing decision dated February 26, 2010. At the hearing, the Administrative Judge found Hollup to be neatly groomed and dressed and had testified readily. He did not find his testimony to be credible, stating that he had difficulty envisioning the industrial accident taking place in the manner in which Hollup testified. In addressing this issue, the Administrative Judge found his varying accounts of the incident through the years to be very instructive. He wrote that "[t]he speed of the truck and the circumstances of the landing/fall [had] become more melodramatic with the passage of time." He concluded that the earliest accounts of the incident in which he described a backwards fall off a sanitation truck resulting in a laceration in the occipital area of the head to be more plausible.[56]

The Administrative Judge also determined Hollup had issues with opiate abuse. He recounted the four reports submitted by Dr. Rater after examining Hollup on October 4, 2006 and August 26, 2008. He wrote that Dr. Rater noted Hollup had multiple prescribers of narcotics, which is a "red flag for opiate dependence." Hollup was noted as having a history of drug abuse that predated his work history and that he, as close to his head injury as August 2004, was misusing opiates. Dr. Rater indicated that the head injury gave him a rationale for opiate requests and that he "successfully pursued that strategy for four years." He concluded the industrial injury to be "a non-factor" and that his current condition was continuous with his pre-existing condition and not altered by his work injury. The Administrative Judge accepted and adopted the opinion of Dr. Rater.[57]

Further, while Hollup associated all his difficulties that he had experienced since September 14, 2004 to the industrial accident, the Administrative Judge did not find that his treating physician endorsed this idea. He wrote that Dr. Smith noted that it was not completely clear from his history that his anger was due to the head injury. He also stated that Dr. Kirsch discussed Hollup's vulnerability to changes in his wife's behavior and his deficits in mood regulation, affective ability, impulse control with aggression, and severe depression. While Dr. Kirsch concluded Hollup was disabled due to his mood instability, extreme emotional reactions, poor response to stress and impulsivity, the Administrative Judge

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[56] Ex. 11.

[57] Ex. 11.

emphasized that Dr. Kirsch could not render an informed opinion as to causality. He also accepted and adopted the statements made by the initial medical panel, who found inconsistencies in Hollup's symptom descriptions. Specifically, the medical panel noted Hollup reported significant improvement of his headaches a year after the injury upon initiation of BiPAP as reported by Dr. Vydrin in September 2005. While reporting frequent nausea and headaches, the panel indicated that Hollup had not required emergency room (ER) visits for headaches since September 18, 2005 and had not requested medications for nausea. The panel found the facts supported Hollup had only a very mild head injury. It concluded that his subjective report of headache pain alone was not adequate to support disability and that his lumbar symptoms would not prevent him from performing the physical aspects of his sanitation work. Accordingly, the Administrative Judge concluded that the accident of September 14, 2004 did not cause his incapacity from employment.[58]

Even in the absence of objective findings of back pain and neurological deficits, Hollup's medical record shows he continued to use Vicodin, Percocet, or Oxycodone throughout 2008.[59] A 2013 record shows continued use of Percocet.[60]

The negative certification by the first regional medical panel in 2008 was binding on the retirement board. It barred the award of accidental disability retirement benefits to Hollup based on the injuries listed on his first application.[61] The first application was based on headaches, dizziness, and back pain. It did not list depression. Thus, on August 31, 2011, Hollup was able to file a further application for accidental disability retirement benefits, also arising from his 2004 fall, based on depression.[62]

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[58] Ex. 11.

[59] Ex. 20 (Dr. Kirsch 1/7/08); Ex. 6 (Dr. Masi 5/15/08); Ex. 19 (psychiatrist Dr. Mark Cutler 6/5/08); Ex. 27 (UMMC summary 7/14/08); Ex. 36 (Dr. Savla 8/5/08); Ex. 19 (Dr. Cutler 9/15/08).

[60] Ex. 38 (psychiatrist Kenneth Jaffe, M.D., 1/7/13).

[61] *See Malden Retirement Bd. v. Contributory Retirement Appeal Bd.*, 1 Mass. App. Ct. 420, 423-425 (1973).

[62] Ex. 12; Finding 65. This was Hollup's third application for accidental disability retirement benefits based on his fall. Previously, on July 21, 2008, shortly after the negative medical panel certification (and before the WRB had issued its denial), Hollup had filed a second application that failed to list any medical disability and that was not accompanied by an updated physician's statement. Ex. 7. On October 6, 2009, having received no additional

3. *History of aggression and mental health treatment before the September 14, 2004 head injury.*

The medical record shows that Hollup began showing significant symptoms of depression in 2006, with a major depressive episode in September 2006, two years after his fall. For many years prior to his fall, however, Hollup also had significant behavioral and mental health issues, including three assignments to anger management programs in 1987, 1999, and 2004 and a 1999 evaluation for depression and impulse control disorder.

In 1987, Hollup reportedly attended his first anger management program after he was involved in a fight while working as a bouncer.[63]

In approximately 1991, Hollup admitted causing a laceration in his ex-girlfriend's forehead that required fifteen stitches and breaking her boyfriend's jaw. He reportedly was incarcerated for four months after the beatings.[64]

In 1999, Hollup was referred to a second anger management program, apparently after an altercation at a fast food restaurant. The October 6, 1999 anger management intake report listed a history of four assault and battery charges, mostly on his prior girlfriend, and a history of fights with men including the use of bats, telephones, sticks, and threats to kill.[65]

On October 19, 1999, Hollup reportedly underwent a psychopharmacology evaluation. The evaluation also referred to a 1999 road rage incident, "physical displays" at his girlfriend, and mood swings from euthymia (normal) to depression, irritability, and anger. The evaluation diagnosed adult ADD (attention deficit disorder), and "rule out major depression and impulse control disorder" with a GAF of 50. Recommendations included antidepressants and anticonvulsants.[66]

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documentation, the WRB wrote Hollup's attorney that it would take no action on the second application. Ex. 10. Hollup took no appeal from that letter. Findings 57-60, 63.

[63] Ex. 28 (report of psychiatrist Dr. Michael Braverman 1/18/06). We rely in part on uncontested reports, admitted into evidence by the magistrate, that recite information based on a review of medical records. *See* G.L. c. 30A, § 11(2).

[64] Exs. 11, 17 (anger management intake 10/6/99; DIA Admin. J. Paul F. Benoit dec. 2/26/10; LICSW Lee Wosky rev. 10/11/13).

[65] Ex. 17 (anger management intake 10/6/99); Exs. 27, 32 (9/14/06), Ex. 15.

[66] Ex. 17 at 7 (LICSW rev., psychopharmacology eval. 10/18/99). Our record does not show whether Hollup received the recommended treatment or medications, which are similar to those he was later prescribed. The GAF or global assessment of functioning scale is used to

On June 25, 2003, Hollup was involved in another road rage incident. He followed the other driver and confronted him, yelling and punching him in the face, slamming the other driver's door, and punching and denting the door.[67] He was placed on probation and assigned to his third anger management program.[68]

In August 2004, a month before his work fall, Hollup was injured while fighting at work. He was pushed through a glass window, causing lacerations to his arm that were sutured. He received Vicodin in the emergency department and another prescription for Vicodin a day later.[69]

4. *Psychiatric treatment following the head injury.*

At the time of his fall, Hollup was still attending the court-ordered anger management program at the University of Massachusetts Mental Health Center (UMMHC) Ambulatory Psychiatric Clinic arising from his 2003 road rage attack on another driver. He attended a total of twenty-two sessions, three of which occurred between September 16-30, 2004. As the program neared its close in September 2004, the therapist leading the group evidently concluded that Hollup needed further psychiatric evaluation and referred him to psychiatrist, Dr. Smith.

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rate how serious a mental illness may be. It measures how much a person's symptoms affect his or her day-to-day life on a scale of 0 to 100. It is designed to help mental health providers understand how well the person can do everyday activities. The score can help figure out what level of care someone may need and how well certain treatments might work. The GAF is based on a scale that was first used in 1962. It has been updated over time. In 2013, the manual that psychiatrists in the U.S. use to define and classify mental disorders dropped it in favor of a scale designed by the World Health Organization. Sabrina Felson, M.D., *What Is The Global Assessment of Functioning (GAF) Scale?* (Feb. 23, 2019), http://www.webmd.com/mental-health/gaf-scale. A GAF scale of 41-50 denotes serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job). *See* DSM-IV-TR, p. 34.

[67] Ex. 16 (Worcester Police report); Ex. 11.

[68] Exs. 21, 11, 19. Hollup was still attending anger management sessions at the time of his work fall on September 14, 2004; the last session was on September 30, 2004.

[69] Ex. 11 (8/19/04 UMMC record cited by Dr. Rater 8/7/09, DIA decision); Ex. 17 at 3 (8/10/04). It was not clear if the fight took place at Hollup's city sanitation job or at his second job driving an ice truck.

Dr. Smith first saw Hollup on September 23, 2004 – nine days after Hollup's fall. Hollup denied depression or sadness, anhedonia, or suicidal thoughts. He did endorse anxiety and identified recent stressor of financial pressures. The focus of the visit, however, was on Hollup's longstanding attention deficit and management of his anger. Dr. Smith diagnosed Hollup with attention deficit hyperactivity disorder (ADHD). [70] He raised the question of whether Hollup might be "bipolar with a rapid cycling," which might relate to his impulsivity and anger, but he believed ADHD was more likely. Dr. Smith wrote that Hollup did "not seem to be experiencing a class[ic] depressive episode."[71]

Although he did not endorse any sadness or anhedonia, Hollup stated that he was prescribed a SSRI - Celexa - about a year to a year and a half ago by his primary care physician, Dr. Milman. He took this for about two weeks but subsequently self-discontinued in part due to the interaction with his drinking schedule (drinking 2 drinks on road trips or 3,4, or 5 drinks at football practice). Due to his history of ADD, he also had a remote history of Ritalin use while a child. Mental status examination did not reveal any significant findings. Hollup presented as cooperative with normal behavior, euthymic mood, slightly anxious affect but full range, largely intact associations, intact recent memory, and intact attention span and concentration. As there were no frank cognitive deficits on examination despite the recent head injury, Dr. Smith did not conduct additional cognitive mental status testing.

Dr. Smith outlined medication treatment options with Hollup. He informed Hollup that stimulants, such as Concerta, which is used in the treatment of ADD and ADHD, could increase violent potential for some patients. Thus, he recommended alternatives to Concerta, such as mood stabilizers and an SSRI like Celexa. Dr. Smith advised resuming the SSRI to be desirable alone or in combination with a stimulant to address his anger and impulsivity difficulties. He did not find Hollup endorsed any history of drug induced hypomania on the Celexa but prefaced that he only took it for two weeks. Ultimately, despite Hollup's history of aggression and his most recent act of road rage in June 2003 for which he was still

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[70] Dr. Smith's intake record refers to "ADD predominantly hyperactive type." Ex. 20. His later notes use the updated designation "ADHD."

[71] Ex. 20 (9/23/04). Dr. Smith also noted "rule out" MDD (major depressive disorder), bipolar disorder NOS (not otherwise specified), alcohol abuse, intermittent explosive disorder, mental disorder NOS due to head trauma, and GAD (generalized anxiety disorder).

attending anger management, Dr. Smith and Hollup agreed to a two (2) week trial of Concerta.[72]

Hollup did well on Concerta, reporting improvement in sleep, self-esteem, concentration, and energy. On October 25, 2004, he explained that he felt more social, even describing sitting at a football game with his father-in-law and not yelling at the referees. He reported engaging in activities not consistent with having a disabling psychiatric condition, including working on and planning construction projects for his home. When Dr. Smith advised him on limiting the scope of his projects due to his limited financial resources, Hollup replied that he always had problems making grandiose plans and found no changes with use of Concerta. Hollup also discussed his concerns of having a difference in opinion with Dr. Milman regarding his recovery process from his head injury. While paranoia can be a side effect of stimulant medicines, he reported being very paranoid in the past with no noted increase in paranoia on stimulants. He actually felt there to be a decrease in paranoia.[73]

On November 29, 2004, Hollup appeared more relaxed and presented as appropriate with no signs of pressured speech or mania. However, around January 2005, with an increase in financial stressors and issues with his tenant, his irritability increased. Hollup also reported increased inflexibility with his wife, his wife's family, and construction workers at his home. Nevertheless, Dr. Smith did not report any significant changes on mental status examinations, but due to his increased symptoms, he elected to discharge Concerta.[74]

Despite his complaints of increased symptoms, Hollup did not return for psychiatric services until later in 2005. In fact, his attorney had referred him for a psychiatric evaluation with Mark Cutler, M.D., a psychiatrist, which was conducted on November 14, 2005. Hollup reported a history of head injury on September 14, 2004 while working as a sanitation worker and a history of ADHD for which Ritalin was prescribed.[75] Dr. Cutler reported that the structure of work kept Hollup functioning, but since the accident, he no longer had that structure resulting in worsened psychiatric symptoms. He assessed him with a pain disorder

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[72] Ex. 20.

[73] Ex. 20 (10/25/04).

[74] Ex. 20 (11/29/04, 1/3/05, 1/12/05).

[75] Ex. 19 (11/14/05). In this version of the accident, Hollup explained that while on the back of a garbage truck that was traveling 30 mph and taking a turn, he fell off the back of the truck, hitting the back of his head against a retaining wall requiring sutures.

associated with both psychological factors and a general medical condition; ADHD; and major depressive disorder. He concluded that Hollup had a pre-existing psychiatric disorder that was exacerbated by the head injury of September 2014. Dr. Cutler determined he could not work and found a causal relationship of his psychiatric disorder and disability to the accident.[76]

Subsequently, Hollup resumed monthly psychiatric treatment with Dr. Smith in December 2005, ten months after he was last treated by him. During this gap in treatment, he reported episodes of behavioral dyscontrol, describing arguments with his wife culminating in some physical contact. He engaged in instigative behavior towards his wife. Based on this reporting, Dr. Smith recommended additional antidepressant medications and initiation of Lithium to treat his moderate to severe depression.[77]

Hollup had similar complaints of emotional distress when he presented for an independent psychiatric examination with Michael Braverman, M.D., on January 18, 2006. Dr. Braverman reported that he had a previous history of psychiatric difficulties and a diagnosis of ADHD. Although he had three assignments to anger management programs, multiple charges of assault and battery and history of fights with men, Hollup conveyed that he was involved in only two episodes of anger management. He also denied that the last incident of road rage in 2003, which led to court mandated anger management, resulted in a physical confrontation. This was contrary to what was written in the police report. While Hollup denied history of alcohol or drug abuse or abuse of prescription medication, the treatment notes from his treating providers indicate otherwise. Dr. Braverman determined ADHD was not Hollup's primary issue. In fact, he indicated that Hollup reported his primary disability was headaches, which was being addressed by Neurology. Without reviewing the medical reports from Hollup's treating psychiatrist, Dr. Braverman concluded he suffered from depression due to his presentation of lability, irritability, restlessness, and depressed mood and determined the work injury to be the predominant and significant contributing cause to Hollup's present symptoms. With appropriate treatment, he believed that Hollup's

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[76] Ex. 19 (11/14/05). Dr. Cutler also reported Mr. Hollup's diagnoses also included hypercholesterolemia, closed head trauma, and hypertension.

[77] Ex. 20 (12/21/05).

symptoms would resolve and allow him to resume employment when his condition stabilized.[78]

Between January and May 2006, Dr. Smith monitored Hollup's response to medication therapy. During this period, he managed Hollup's medication regimen to optimize his symptom control. Dr. Smith titrated his dose of Lithium in January 2006 due to lack of efficacy. Hollup continued to complain of anxiety, headaches, lack of energy, and word finding difficulties, but he improved by May 2006, reporting decreased anxiety and improvement in headaches. He was calmer at home and getting along with his wife. As of May 24, 2006, he was on a regimen of Cymbalta, Topamax, Seroquel, and Vicodin. He was subsequently prescribed Lyrica to manage his headaches and complaints of neuropathic back pain.[79]

Based on his evaluation of Hollup in May 2006, Dr. Smith determined that his mood and affect were influenced by his pain symptoms. Therefore, he referred him for anger management and psychotherapy. Hollup initiated psychotherapy with Lynn Dowd, Psy.D., a psychologist, in June 2006.[80] The individual therapy notes from June, July, and August 2006 reflect that treatment focused on addressing his anger, aggression, and recurrent depression. His specific problems were reported as an adjustment disorder in conduct and major depression in partial remission. While Hollup maintained that his increasing anger and explosiveness were due to his head injury and medication, Dr. Dowd explained that stress and depression also contributed to his irritability. The treatment notes reflect that as marital and family discord increased, Hollup's anger and irritability also increased. In July 2006, Dr.

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[78] Ex. 28. Dr. Braverman admitted that he did not review medical records from Hollup's treating psychiatrist. Those medical records indicate that Hollup was referred for treatment to address his ADHD and history of anger management issues, which predated and continued after the head injury. Dr. Smith also noted Hollup suffered from alcohol abuse and intermittent explosive disorder. There was a significant gap in treatment and increased stress related to financial problems and marital discord, resulting in increased psychiatric symptoms. See Ex. 20 (9/23/04, 10/25/04, 11/29/04, 1/3/05, 1/12/05).

[79] Ex. 20 (1/24/06, 2/16/06, 3/23/06, 4/6/06, 5/4/06, 5/24/06).

[80] Ex. 20 (06/20/06). Ambulatory Services Record note completed by Dr. Dowd reflect Hollup complained of increased aggression and impulsivity. Hollup discussed recent aggressive episode, conflict with wife, family illness and conflict with in-laws during the individual therapy session. Dr. Dowd wrote that Hollup commented: "I feel depressed. I'm gaining weight…She's ridiculing me."

Dowd reviewed with him stressors affecting his marriage, including financial problems, the impending death of his father-in-law, and his medical condition. Noticeably, Dr. Dowd observed Hollup was extremely relaxed, was in good spirits, and appeared more stable and in better control in August 2006 after the passing of his father-in-law and improvement in his marital relationship.[81]

Hollup was last seen by Dr. Smith in June 2006. At that time, his medication regimen included Cymbalta, Topamax, Seroquel, and Vicodin. Dr. Smith emphasized at that time to minimize his use of Vicodin, as it could worsen his anger. He encouraged him to consider substance abuse treatment due to minor withdrawal symptoms from substances.[82]

Dr. Smith then referred Hollup for treatment with Daniel Kirsch, M.D., another psychiatrist. Dr. Kirsch first evaluated him on July 20, 2006. Again, Hollup reported that he had been receiving treatment for depression and aggression following a head injury.[83] He reported that his prior anger problems were mostly verbal outbursts.[84] He attributed his increased aggression to the head injury. Again, Hollup complained of increased stress, coinciding with assault charges filed by his wife, divorce concerns, and the potential loss of his home. This culminated in his psychiatric hospitalization at UMMC from September 14-18, 2006 for which he was treated with Seroquel and Percocet for an assessment of impulse control disorder and r/o bipolar mood disorder currently mixed.[85]

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[81] Ex. 20 (6/20/06, 6/28/06, 7/11/06, 7/18/06, 7/25/06, 8/17/06).

[82] Ex. 20 (6/28/06).

[83] Ex. 20 (7/20/06). In this version of the accident, Hollup reported working as a sanitation worker and had fallen off the back of a garbage truck that was traveling 40 mph resulting in a head injury.

[84] Although Hollup reported that problems with his anger were mostly verbal outbursts, the medical records prior to his head injury of September 2004 reflect that he had an altercation at a fast food restaurant in 1999 resulting in his second anger management assignment, that he has a history of multiple assault and battery charges, mostly on his prior girlfriend, a history of fights with men including the use of bats, telephones, sticks, and threats to kill, a road rage incident in June 2003 resulting in a physical confrontation and assignment to his third anger management program, and a physical altercation at work in August 2004. Ex. 11 (8/19/04 UMMC record cited by Dr. Rater 8/7/09, DIA decision); Ex. 17 (anger management intake 10/6/99 and LICSW rev., psychopharmacology eval. 10/18/99); Exs. 27, 32 (9/14/06), Ex. 15.

[85] Ex. 20 (7/20/06, 9/13/06, 9/14/06). The psychiatric hospitalization was also discussed in the report by Robert Mills, Claims Director, and Lee Wosky, L.I.C.S.W., Senior Psychiatric Consultant, for Disability Management Services, Inc.

After his psychiatric hospitalization in September 2006, Hollup continued psychiatric treatment with Dr. Kirsch. Again, the medical records reflect there to be a correlation between Hollup's aggression and his marital relationship. Specifically, Dr. Kirsch noted on October 11, 2006 that he was vulnerable to changes in his wife's thinking and behavior. He stated that if his wife rejected him or he experienced her rejecting him, he was vulnerable to acute decompensation with severe depression and suicidal thoughts. These were noted deficits in Hollup's mood regulation and impulse control ability. When he was able to avoid fights with his wife, Hollup's mood was more stable. Dr. Kirsch determined Hollup was disabled due to mood instability, extreme emotional reactions, and poor response to stress and impulsivity. However, he could not render an informed opinion as to causality.[86]

While being managed medically by Dr. Kirsch, Hollup continued psychotherapy with Dr. Dowd between September and November 2006. He was able to manage his anger and aggression in his marital relationship by implementing strategies learned through therapy. Dr. Dowd found him to be only mildly to moderately depressed and anxious, had brighter affect and mood, was clean shaven, and dressed with more care. She concluded there to be a strong link between Hollup's divorce concerns and his disabled status. With his wife filing for divorce and financial issues arising from bankruptcy proceedings and the foreclosure of his home, Hollup's aggression increased and his ability to control his behavior deteriorated. His wife obtained a restraining order due to threats to take the air out of her tire, bending her antenna, and following her to her home in his car. Therapy notes reflect Hollup continued to be highly distressed due to the instability in his marriage.[87]

Although there was a period of increased depression due to lack of medication therapy stemming from his loss of insurance, treatment notes from Dr. Kirsch reflect Hollup's psychiatric symptoms were controlled with medications. On April 14, 2008, Dr. Kirsch indicated that while he was previously more labile, either severely depressed or approaching mania in the setting of distress, Hollup was observed to be in good control and able to listen to his comments. He expressed that Hollup recognized he was better able to handle things even

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[86] Ex. 20 (10/11/06, 11/13/06).

[87] Ex. 20 (9/21/06, 10/10/06, 10/26/06, 11/2/06, 11/30/06, 5/1/07).

with difficulties at home. Dr. Kirsch also observed that Hollup was better groomed and was more alert than usual.[88]

On December 17, 2007, Bennet Aspel, M.D., conducted an independent psychiatric examination. Hollup reported that he felt overwhelmed from family issues and financial concerns. Dr. Aspel assessed Hollup with a mood disorder secondary to post-concussion syndrome; intractable headaches secondary to post-concussion syndrome; chronic back pain secondary to degenerative disc disease; ADHD; sleep apnea; history of alcohol abuse; high blood pressure; and hypercholesterolemia. He reported that his alcohol, anger, and ADHD history predated his injury. He determined Hollup was disabled, finding that the accident and subsequent post-concussion syndrome to be the root of his disability. He concluded his headaches and mood swings were permanent, but only until they were better controlled with treatment.[89]

Hollup also had worsening depression from stress related to being newly diagnosed with diabetes mellitus in March 2008. On March 3, 2008, Dr. Kirsch implemented a more aggressive antidepressant medication therapy to address this.[90]

Upon a request by his attorney to provide a narrative discussing Hollup's psychiatric issues in connection with his application for accidental disability retirement benefits, Dr. Kirsch explained on October 4, 2006 that his psychiatric history of ADD and impulsivity dated back many years. He noted that he sustained a head injury on or about September 15, 2004 when he fell off a truck. He stated that he was treated by Neurology and referred for anger management by Dr. Smith. He noted that Dr. Smith evaluated him with a diagnosis of ADD. Dr. Kirsch reported that Hollup presented with episodes of impulsivity, depression, and anger management issues. He found that he demonstrated problems with concentration, appropriate interaction with peers, and with modulating his impulses. Dr. Kirsch determined

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[88] Ex. 20 (7/17/2007, 8/28/07, 10/30/07, 1/7/08, 4/14/08)

[89] Ex. 37. Dr. Aspel was requested by DIA to conduct this independent medical examination. During this examination, Hollup reported sustaining a workplace injury on September 14, 2004 when he was thrown off a garbage truck, struck the back of his head and lower back and lost consciousness. While Dr. Aspel concluded that the accident and subsequent post concussion syndrome to be the root of his disability, the first medical panel subsequently concluded that he did not have a neurological disability. Ex. 6; FF 39, 54.

[90] Ex. 20 (3/3/08).

from his history that his problems were significant enough to be disabling and likely to be permanent. However, he could not assign causation in his capacity as Hollup's treating physician.[91]

Hollup's attorney again requested Dr. Cutler to perform psychiatric re-evaluations in June and September 2008. On June 5, 2008, Hollup reported having sustained a head injury from a fall off a garbage truck.[92] He complained of headaches and symptoms of depression, as well as a history of angry outbursts. While he was not receiving psychotherapy, he was engaged in psychiatric treatment every three months with a psychiatrist. Dr. Cutler's assessment was pain disorder associated with both psychological factor and general medical condition; ADHD; and major depressive disorder. Dr. Cutler concluded it was unlikely Hollup's pain disorder would be alleviated enough for him to return to work.[93]

In his psychiatric evaluation report of September 15, 2008, Dr. Cutler noted Hollup continued to experience anergia, anhedonia, decreased concentration, irritability, decreased libido, decreased sleep, recurrent thoughts of the accident, and chronic headaches and pain since the accident. Hollup admitted to taking an extra Oxycodone when feeling a headache coming on. Mental status examination showed he was appropriately dressed and fully oriented. While he appeared depressed and preoccupied with his headache, Hollup exhibited no thought disorder, no pressured speech, no flight of ideas, no loose associations, and no suicidal or homicidal ideations. Nevertheless, Dr. Cutler concluded Hollup had a psychiatric disability and the work-related injury to be the prominent contributing factor. He maintained a prognosis for the pain disorder to be very guarded given the length of time since the accident, but noted a much better prognosis for his depressive disorder, which is the basis for his third application for accidental disability retirement. Dr. Cutler did not review medical

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[91] Ex. 33 (10/4/06). Although Dr. Kirsch indicated the accident occurred on September 15, 2004, the correct date of the accident is September 14, 2004.

[92] In this version of the accident, Hollup reported sustaining a head injury at work when the driver of the garbage truck hit a rut in the road, causing him to be thrown off hitting the back of his head and lower back against a retaining wall. He again reported loss of consciousness.

[93] Ex. 19 (6/5/08).

records from Dr. Kirsch. Instead, he reviewed limited medical records made available by Hollup's attorney.[94]

In his hearing decision regarding Hollup's claim for Workers' Compensation benefits dated February 26, 2010, Administrative Judge Paul F. Benoit reviewed and summarized the findings from Dr. Rater's most recent IME report of August 7, 2009. According to Dr. Rater, the medical records show evidence of opiate abuse, physical and verbal aggression, and work problems one month before the work fall in question. Dr. Rater stated that Hollup has a history of drug abuse that predated the industrial injury. He indicated that as recently as August 2004, Hollup was noted as misusing opiates. Administrative Judge Benoit quoted Dr. Rater as stating that having multiple prescribers of opiates is a "classic red flag for opiate dependence." Dr. Rater explained that "the head injury gave [Hollup] a rationale for opiate requests and pursued that strategy for four years." He concluded that the industrial injury was a "non-factor" in his current condition, that his current condition was continuous with his pre-existing condition and not altered by his work injury, and that his current condition was the same in terms of frequency, intensity, and duration as his pre-injury history and showed no signs of worsening. Ultimately, Dr. Rater determined that Hollup's pre-existing problems were consistent with his current problems and not worsened by his work injury. [95]

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[94] Ex. 19 (9/15/08). Dr. Cutler noted in his re-evaluation report that he reviewed the following medical records provided by Hollup's attorney: copies of his psychiatric evaluation and re-evaluation of 3/14/07 and 7/18/07; IME by Dr. Savla dated 3/14/07; and an IME report by Dr. Aspel dated 12/30/07 for DIA. In his psychiatric re-evaluation of September 15, 2008, Dr. Cutler was provided the following medical records for review by Hollup's attorney: copies of his psychiatric evaluations; medical evaluation of Dr. Savla dated 8/5/08; Physician's Statement Pertaining to Member's Application for Disability Retirement; psychiatric evaluation and record review by Dr. Rater dated 10/4/06; an addendum to a psychiatric evaluation and record review dated 11/28/06; evaluation of Dr. Savla dated 3/14/07; medical evaluation of Dr. Anderson dated 10/4/06; and an IME report by Dr. Aspel dated 12/30/07.

[95] Ex. 11. Administrative Judge Benoit indicated that Dr. Rater examined Hollup on October 4, 2006 and August 26, 2008 and wrote four reports concerning Hollup. His hearing decision referenced medical reports that Dr. Rater used as evidence to substantiate Hollup's opiate abuse: 8/19/04 -Hollup seen at UMMC for right arm pain the day before and received 16 Vicodin. He used 12 Vicodin in one day and returned for a refill. His diagnosis included drug abuse; 9/18/04 – Hollup seen at UMMC for complaints of nausea, dizziness on standing, and headache. He reported accidently throwing away his Vicodin the day before; 9/21/04 – Hollup reported loss of consciousness in the industrial accident and received 20 Vicodin from Dr. Li; 12/2005 – Dr. Smith reported Hollup was drinking up to 6 drinks at a time. Hollup

The last records addressing Hollup's disability were from 2013. During an independent psychiatric examination conducted by Kenneth Jaffe, M.D., on January 2, 2013, Hollup reported having long-standing problems with his temper, which had worsened since the accident. He complained of difficulties with memory and concentration. He endorsed symptoms of depression, including but not limited to feeling sad, feelings of failure, lack of satisfaction, disappointment in himself, crying spells, irritability, loss of interest in other people, difficulty making decisions, feeling unattractive, difficulty sleeping, fatigue, decreased appetite, and worries about physical problems. Dr. Jaffe assessed him with a major depressive disorder, PTSD, chronic, and ADHD by history. He determined Hollup was totally disabled due to the severity of his depression, chronic headaches, and difficulty with memory, concentration, and irritability. He concluded his condition to be permanent, that his current psychiatric disability was causally related to his work accident of September 2004, and that he had reached a medical end result. In making this determination, Dr. Jaffe could not discern how much his difficulty with memory and concentration were related to his head injury and the amount related to the fairly large dose of Percocet. He also noted that a large dose of Topamax frequently causes difficulty with memory and concentration. He suggested that reducing the dose could improve his concentration and memory.[96]

Dr. Kirsch provided an updated report on December 20, 2013, seven years after his initial report in 2006 and nine years after the head injury. He noted that Hollup stated he lost consciousness in the accident. He concluded Hollup was totally and permanently disabled as a result of the accident, which he could not previously determine in October 2006. He based this finding on his years of treatment and a review of other medical records and evaluations.[97]

Discussion

1. *Claim for accidental disability retirement benefits based on psychiatric disability.*

To qualify for accidental disability retirement benefits, an employee must show that he is "unable to perform the essential duties of his job and that such inability is likely to be

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was taking Percocet and Vicodin daily; 2/22/06 – Dr. Groves noted a history of drug abuse but still prescribed opiates; 5/31/06 – Dr. Milman prescribed opiates for back pain; 7/25/07 – Dr. Vydrin prescribed additional Percocet; and 11/2007 Dr. Milman prescribed Percocet.

[96] Ex. 38. This IME was conducted for the DIA.

[97] Ex. 39.

permanent…by reason of a personal injury sustained or hazard undergone as a result of, and while in the performance of, his duties." G.L. c. 32, § 7(1).[98] Upon application for accidental disability retirement benefits, the applicant must demonstrate that a disability "stemmed from a single work-related event or series of events" or "if the disability was the product of gradual deterioration, that the employment [had] exposed [the employee] to an identifiable condition…that is not common or necessary to all or a great many occupations." *Blanchette v. Contributory Retirement Appeal Bd.*, 20 Mass. App. Ct. 479, 485, 481 N.E.2d 216, 220 (1985).

A mental or emotional disability has been recognized as a personal injury within the meaning of G.L. c. 152, *see Kelly's Case*, 394 Mass. 684, 686, 477 N.E.2d 216 (1985), and can serve as the basis for granting accidental disability retirement benefits. *Fender v. Contributory Retirement Appeal Bd.*, 72 Mass. App. Ct. 755, 761-762, 894 N.E.2d 295 (2008); *Blanchette*, *supra* at 485.

The aggravation of a pre-existing condition by a work injury is also compensable under G.L. c. 32. *Robinson v. Contributory Retirement Appeal Bd.*, 20 Mass. App. Ct. 634, 638 (1985). If a condition or incident at work aggravates a pre-existing health problem, the employee has suffered a personal injury and may recover from the employer for his entire disability without apportionment. *Zerofski's Case*, 385 Mass. 590, 593, 433 N.E.2d 869 (1982). For a mental or emotional disability, the applicant must show that the predominant cause of the injury was work-related.[99]

For accidental disability retirement benefits, a medical panel is convened to examine the applicant. Its 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 Appeal Bd.*, 1 Mass. App. Ct. 420, 423, 298 N.E.2d 902, 904 (1973).

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[98] Personal injury is not defined in Chapter 32, the retirement laws. However, the Supreme Judicial Court indicated that "it is settled that the term "personal injury," as it appears in G.L. c. 32, § 7, should be interpreted similarly to the same term in G.L. c. 152." *Adams v. Contributory Retirement App. Bd.*, 414 Mass. 360, 361 n.1, 609 N.E.2d. 62, 63 n.1 (1993). Chapter 152 is referred to as the Workers' Compensation Statute.

[99] According to M.G.L. c. 152 § 1(7A), "[p]ersonal injuries shall include mental or emotional disabilities only where the predominant contributing cause of such disability is an event or ~~series of events~~ occurring within any employment."

A medical panel's certificate answering in the affirmative to questions of incapacity, permanence, and causation is a condition precedent to granting benefits. *Quincy Retirement Bd. v. Contributory Retirement Appeal Bd.*, 340 Mass. 56, 60 (1959); *Campbell v. Contributory Retirement Appeal Bd.*, 17 Mass. App. Ct. 1018, 1019 (1984). It is the local retirement board, however, that makes the ultimate decision to allow or deny accidental disability retirement benefits based on the relevant evidence. G.L. c. 32 § 7. *See Kelley v. Contributory Retirement Appeal Bd.*, 341 Mass. 611 at 614, 171 N.E.2d 277 (1961).

In his first application for accidental disability retirement benefits filed on August 11, 2006, Hollup cited disability from closed head trauma, concussive syndrome, and a herniated disc, which resulted in a negative certification by a regional medical panel composed of two neurologists and a specialist in internal medicine. This regional medical panel concluded on July 7, 2008 that Hollup did not have a neurological disability.[100]

The WRB did not act on Hollup's second application for accidental disability retirement benefits based on the same injury for reasons discussed above. Hollup made no further appeal on that matter.[101]

In his third application for accidental disability retirement benefits filed on August 31, 2011, Hollup was precluded from claiming a neurological disorder based on the same injury as a result of the negative certification from the first medical panel. However, he was not precluded from claiming a psychiatric disability stemming from the same injury, which is the basis of this claim.[102]

On November 17, 2014, the psychiatric medical panel, consisting of three psychiatrists, Michael Kahn, M.D., Susannah Sherry, M.D., and George Dominiak, M.D., unanimously answered the three questions of incapacity, permanence, and causation in the affirmative. The panel determined that Hollup met the criteria for aggravation of a pre-existing condition standard and rendered a working diagnosis of a major depressive disorder; neurocognitive disorder due to traumatic brain injury; and personality disorder NOS. [103] Nevertheless, the WRB denied Hollup's application for accidental disability retirement

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[100] Ex. 6; FF 54.

[101] Ex. 10.

[102] Ex. 12.

[103] Ex. 15; FF 68-69.

benefits. The DALA magistrate reversed the WRB's decision, relying heavily on the unanimous decision of the psychiatric medical panel. She concluded that Hollup met his burden of proving by a preponderance of the evidence that the September 14, 2004 head injury resulted in the aggravation of his pre-existing ADHD and mood disorders. [104]

Hollup bears the burden of proving each element of his benefit claim by a preponderance of the evidence. *Lisbon v. Contributory Retirement Appeal Bd.*, 41 Mass. App. Ct. 246, 255, 670 N.E.2d 392 (1996); *Daley v. Contributory Retirement Appeal Bd.*, 60 Mass. App. Ct. 1110, 801 N.E.2d 324 (2004). We conclude that he has not met his burden. Hollup did not show by a preponderance of the medical and non-medical evidence that the head injury of September 2004 aggravated his pre-existing psychiatric conditions. Here, the medical and non-medical evidence demonstrates that Hollup's current psychiatric conditions were continuous with his pre-existing psychiatric conditions and not altered by the head injury. Assuming that Hollup has a psychiatric disability that later matured, Hollup failed to show that he was psychiatrically disabled at the time he last performed his duties as a sanitation worker. Moreover, the underlying evidence in the record points to other causes that significantly contributed to his psychiatric disability. We, therefore, disagree with the DALA decision to grant Hollup accidental disability retirement benefits.

2. *Psychiatric conditions not altered by head injury of September 2004.*

Hollup has a history of ADHD and aggressive behavior that existed prior to the head injury. He was diagnosed and treated for ADHD in childhood. He had three assignments to anger management in 1987, 1999 and in June 2003. The last anger management program was initiated in April 2004 for a road rage incident in June 2003. Hollup was still attending that anger management program when the head injury occurred in September 2004. His history included assault and battery charges, mostly against his former girlfriend. In approximately 1991, Hollup admitted to causing a laceration to his girlfriend's forehead, requiring fifteen stitches, and breaking the jaw of her boyfriend. He received four months incarceration for those events. His history also included fights with men using bats, telephones, sticks, and threats to kill. Hollup had a psychopharmacology evaluation in October 1999 and was recommended antidepressant and anticonvulsant medication therapy. Just one month prior to

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[104] DALA Decision p. 21.

the head injury, Hollup was involved in a fight at work in August 2004, where he was thrown against a glass window, requiring medical treatment.[105]

Near the end of his anger management treatment for the road rage incident of June 2003, Hollup's licensed social worker, who facilitated the sessions, felt that he required further treatment, and therefore, recommended a psychiatric evaluation with Dr. Smith in September 2004. Her recommendation appeared unrelated to the head injury, but was based on his participation in the anger management program that began in April 2004.

According to the psychiatric medical panel, Hollup did not receive psychiatric treatment prior to the head injury, but began treatment after the fall, supporting the conclusion that his psychiatric symptoms were aggravated by the head injury necessitating treatment.[106] The DALA magistrate agreed with the psychiatric medical panel. Although Hollup attended anger management prior to the head injury, the DALA magistrate declined to recognize it as psychiatric treatment. We disagree with the DALA magistrate. Individuals, who present with complaints of anger, most commonly displayed psychiatric symptoms of irritability and agitation and were frequently diagnosed with mood disorders.[107] Hollup presented with those psychiatric symptoms, and the medical records reveal years of acts of violence, necessitating assignments to anger management. Anger management deals with an emotion – anger – and is a form of psychiatric treatment, addressing a disturbance in emotion regulation which, by definition, is a psychiatric disorder.[108] Based on the above and the fact that the program Hollup attended was administered through the UMASS Mental Health Center Ambulatory Psychiatric Clinic, we conclude that anger management is a form of psychiatric treatment.

In conjunction with anger management, treatments with antidepressants, anticonvulsants, and low-dose anti-psychotics have also been prescribed to address anger

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[105] Hollup's psychiatric history was discussed in Part 3 *History of aggression and mental health treatment before the September 14, 2004 head injury* of the Background section above.
[106] DALA decision p. 23.
[107] Nate L. Ewigman, M.S., M.P.H., Julius A. Gylys, Ph.D., Jeffrey S. Harman, Ph.D., *The Diagnosis of Anger as a Presenting Complaint in Outpatient Medical Settings* (September 2013), Psychiatric Services, ps.psychiatryonline.org, Vol. 64, No. 9.
[108] DSM-5 defines a psychiatric disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function."

issues.[109] Hollup reported that he was prescribed Celexa (or Citalopram), a SSRI, by his primary care physician.[110] He was also prescribed Ritalin for ADHD. The DALA magistrate was under the impression that psychiatric treatment entails taking medications that are prescribed by a licensed psychiatrist.[111] Treatment with medications to address mood or behavioral symptoms is a form of psychiatric treatment. Further, Hollup underwent a psychopharmacology evaluation on October 19, 1999. The evaluation diagnosed adult ADD and rule out major depression and impulse control disorder. Recommendations included antidepressants and anticonvulsants.[112] The implication of this evaluation was that the psychopharmacology evaluator felt Hollup needed further treatment of his psychiatric conditions. Overall, the evidence shows that Hollup's psychiatric symptoms were present before the head injury, for which he received psychiatric treatment, which included medication and anger management. Psychiatric treatment continued after the head injury for the same or similar psychiatric symptoms. Therefore, his psychiatric conditions were continuous with his pre-existing psychiatric conditions and not altered by the head injury.[113]

This point was addressed by Dr. Rater, who examined Hollup on October 4, 2006 and August 26, 2008 in connection with his Workers' Compensation claim. Dr. Rater submitted four extensive reports that were reviewed by the DIA Administrative Judge. In his first report

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[109] Joseph Goldberg, M.D., WebMd Medical Reference, http://www.webmd.com/mental-health/anger-management#1 (last reviewed Sept. 23, 2018).

[110] This medication is used to treat depression. It may improve energy level and feelings of well-being. It works by helping to restore the balance of a certain natural substance (serotonin) in the brain. www.webmd.com/drugs/2/drug-8603/celexa-oral/details.

[111] DALA decision p. 23.

[112] Ex. 17.

[113] In rejecting the psychiatric medical panel opinion, we note that in a recent Rule 1:28 decision, *Morse v. Contributory Retirement Appeal Bd.*, 2019 WL 7286919 (Dec. 30, 2019), where CRAB relied on nonexpert evidence to conclude that the applicant's alcohol dependency problem, as well as her depression and anxiety, started at the time of her first divorce and that her alcohol dependency continued even after she stopped her employment, the court determined that CRAB acted within its discretion to reject the medical expert evidence. *Narducci v. Contributory Retirement Appeal Bd.*, 68 Mass. App. Ct. 127 (2007). The court also relied on *Lisbon v. Contributory Retirement Appeal Bd.*, 41 Mass. App. Ct. 246, 255-257 (1996), which determined that even when the medical panel submitted an affirmative certification and the physician opinion was favorable to the applicant, it was reasonable for CRAB to find lack of causation when there is evidence to show the applicant's longstanding health problems.

dated October 4, 2006, he indicated that Hollup had a pre-existing history of alcohol abuse and mood disorder and presented with diagnoses of ADHD; opiate dependence; history of alcohol abuse; mood disorder NOS; and post traumatic stress disorder (PTSD), chronic. He determined that the industrial injury was a "non-factor" to his current condition. He could not reasonably attribute Hollup's psychiatric symptoms to his work injury since he had all the symptoms prior to the injury and there were plausible alternative explanations for the psychiatric and behavioral symptoms.[114] Therefore, he found no causal connection between the head injury and any aggravation of Hollup's psychiatric symptoms, but determined that his psychiatric conditions were continuous with his pre-existing conditions.

Because there is substantial evidence in the record showing that Hollup's psychiatric conditions were continuous with his pre-existing conditions and not altered by the head injury of September 2004, we disagree with the DALA decision that Hollup showed by a preponderance of the evidence that the head injury of September 2004 aggravated his psychiatric conditions.

3. *In the alternative, later maturing psychiatric disability.*

Assuming that Hollup has a psychiatric disability that prevents him from performing the essential duties of his job, his claim for accidental disability retirement benefits cannot be granted, because Hollup cannot claim a later maturing disability as a basis for accidental disability retirement benefits. *Vest v. Contributory Retirement Appeal Bd.*, 41 Mass. App. Ct. 191 (1996) (employee who has left government service without established disability may not, after termination of government service, claim accidental disability retirement status on basis of subsequently matured disability). Since *Vest*, this legal principle has been extended to mean the employee must establish that he or she was permanently unable to perform the essential duties of his or her position as of the last day the employee actually performed those duties. *Bergeron v. Quincy Retirement Bd.*, CR-01-628 (Jan. 30, 2003); *Maccarone v. Lawrence Retirement Bd.*, CR-04-201 (Nov. 18, 2005); *Gill v. Massachusetts Teachers' Retirement System*, CR-07-280 (July 8, 2011). This includes claims for emotional disabilities. Thus, Hollup must establish that he suffered from a matured and established psychiatric disability at the time he was last in active performance of his duties.

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[114] Ex. 35.

Here, Hollup failed to prove that his psychiatric conditions were disabling as of the last day he performed his duties as a sanitation worker. He began showing significant signs of depression in 2006 with a major depressive episode in September 2006, two years after his fall. Any increased psychiatric and behavioral symptoms he may have experienced were too far removed from the date of the accident to have a causal connection. Dr. Rater even noted after his examination of Hollup in October 2006 that any acute cause of increased psychiatric and behavioral symptoms were no longer applicable as it had been two years past his head injury.[115]

Further, not too long after the fall and prior to the psychiatric hospitalization in September 2006, Hollup displayed abilities that were inconsistent with having matured and established disabling psychiatric conditions. The medical records indicate that Hollup attended football games and practices, cooked, operated a power lawn mower, cared for a son with ADD and a disabled cousin, and managed home construction projects. He was also involved in addressing landlord-tenant issues relating to his rental property, bankruptcy proceedings, and the foreclosure of his home. Following *Vest*, the overall evidence in the record fails to show Hollup had a matured and established psychiatric disability at the time he last performed his duties. For this reason, we conclude that Hollup failed to meet his burden of showing by a preponderance of the evidence that his head injury of September 2004 aggravated his pre-existing psychiatric conditions at the time he last performed his duties as a sanitation worker.

4. In the alternative, other causes of psychiatric disability.

Again, assuming that Hollup has a psychiatric disability that prevents him from performing the essential duties of his job, he has to prove that it is more likely than not that his psychiatric disability is the "natural and proximate" result of the head injury he sustained on September 14, 2004, which is the basis of his claim. G.L. c. 32, § 6(a); *Malden*, 17 Mass. App. Ct. at 1019; *Lisbon*, 41 Mass. App. Ct. at 255. Here, there is substantial evidence in the record pointing to other causes of his psychiatric disability. These include family and marital discord, financial stressors, overuse of medications and opiate dependence, and an

[115] Ex. 11, 20.

unstructured life. The medical records reflect that these issues were significant contributing causes of Hollup's psychiatric disability.

In order for an injury to be the "natural and proximate" cause of Hollup's disability, his injury must be more than a "contributing" or "aggravating" factor to his pre-existing condition. *Blanchette*, 20 Mass. App. Ct. at 485; *Campbell*, 17 Mass. App. Ct. at 1019. *See also Burke v. Contributory Retirement Appeal Bd.*, 34 Mass. App. Ct. 212, 213 (1993). The Supreme Judicial Court has determined that for an event of employment to be more than a "contributing cause," it must be "a significant contributing cause to [the] employee's disability." *Ann Marie Robinson's Case*, 416 Mass. 454, 460, 623 N.E.2d 478 (1993).

While the majority psychiatric medical panel answered all three questions of incapacity, permanence, and causation in the affirmative, its opinion on causality is "not conclusive of the ultimate fact," but is "some evidence on the issue." *Blanchette*, 20 Mass. App. Ct. at 483, 481 N.E.2d at 219. Its certification is only a statement of "medical possibility." *Lisbon,* 41 Mass. App. Ct. at 254, 670 N.E.2d at 398, *quoting Noone v. Contributory Retirement Appeal Bd.*, 34 Mass. App. Ct. 756, 762, 616 N.E.2d 126 (1993). The final determination as to whether causation was proved is reserved to CRAB, "based on all the facts found and all the underlying evidence, including both the medical and non-medical facts." *Blanchette*, *supra.*

While treating with Dr. Smith, Hollup conveyed his difficulties resulting from family and marital discord and financial issues. Dr. Smith's treatment records reflect that these issues played a significant role in his increased psychiatric symptoms. Dr. Smith reported that around January 2005, Hollup began experiencing increased irritability due to financial stressors and payment issues with his rental property. He also reported increased inflexibility with his wife, his wife's family, and the construction workers engaged in his home improvement project.[116]

Dr. Dowd also expressed in her psychotherapy progress notes that as marital and family discord increased, Hollup's anger and irritability also increased. Specifically, in July 2006, Dr. Dowd reviewed with Hollup stressors affecting his marriage, which included financial problems, the illness of his father-in-law, and his medical condition. Noticeably, Dr.

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[116] Ex. 20 (1/3/05, 1/12/05).

Dowd observed that Hollup was extremely relaxed and in good spirits and that he appeared more stable and in better control in August 2006 after the passing of his father-in-law and after noted improvement in his marital relationship.[117] Between September and November 2006, progress notes also showed a strong link between Hollup's marital and family discord and his psychiatric disability. With his wife filing for divorce and financial issues arising from bankruptcy proceedings and the foreclosure of his home, Dr. Dowd noted Hollup was highly distressed due to instability in his marriage and family life.[118] At the end of November 2006, Dr. Dowd found Hollup was unstable due to his likely divorce. Hollup had a dispute with his wife regarding assistance with the bankruptcy process and the foreclosure of his home. He noted his wife obtained a new restraining order after he threatened to take the air out of her tires, bent her antenna, and followed her home.[119]

The increased interpersonal conflicts and stressors ultimately led to Hollup's psychiatric hospitalization at UMMC from September 14-18, 2006. Hollup reported being distressed due to assault charges filed by his wife, his potential divorce, conflict with his son, caring for a handicapped cousin, and the threat of losing his home. He was treated for impulse control disorder and r/o bipolar mood disorder currently mixed.[120]

The medical records from Dr. Kirsch also reflect there to be a correlation between Hollup's increased psychiatric symptoms and family and marital discord. As Dr. Kirsch indicated on October 11, 2006, Hollup was vulnerable to changes in his wife's thinking and behavior. Dr. Kirsch noted that if his wife rejected him or he experienced her rejecting him, he was vulnerable to acute decompensation with severe depression and suicidal thoughts. Dr. Kirsch stated that these were noted deficits in Hollup's mood regulation and impulse control ability. When he was able to avoid fights with his wife, Hollup's mood was more stable.[121] In March and April 2008, Dr. Kirsch noted Hollup was depressed, had low energy, was

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[117] Ex. 20 (6/20/06, 6/28/06, 7/11/06, 7/18/06, 7/25/06, 8/17/06).

[118] Ex. 20 (9/21/06, 10/10/06, 10/26/06, 11/2/06, 11/30/06, 5/1/07).

[119] Ex. 20 (11/30/06).

[120] Ex. 20 (7/20/06, 9/13/06, 9/14/06). The psychiatric hospitalization was also discussed in the report by Robert Mills, Claims Director, and Lee Wosky, L.I.C.S.W., Senior Psychiatric Consultant, for Disability Management Services, Inc.

[121] Ex. 20 (10/11/06, 11/13/06).

irritable and not sleeping well. These symptoms were related to increased interpersonal conflicts with his son and wife, culminating in his request for additional psychotherapy.[122]

In an IME report of October 2006, Dr. Rater remarked that Hollup's problems of irritability and conflict were explained by his history of marital conflict and substance abuse. Therefore, he could not attribute Hollup's psychiatric symptoms to his head injury of September 2004.[123]

As noted by Dr. Rater, the medical record demonstrates that medication overuse and opiate dependence also contributed to Hollup's increased psychiatric symptoms. In treating Hollup, Dr. Smith noted concerns that use of Concerta would increase his violent potential.[124] In October 2004, Dr. Venema determined Hollup's headaches could have been a component of an analgesic rebound phenomena.[125] In November 2004, Dr. Savla determined that his headaches were likely due to muscle contractions and medication overuse.[126] After prescribing him Percocet on April 14, 2006, Dr. Vydrin warned Hollup of analgesic rebound headaches with use of Tylenol and Percocet and possible dependency.[127] In fact, on June 29, 2007, he found Hollup was a bit overwhelmed with medications.[128] The first medical panel also concluded on May 15, 2008 that Hollup presented with possible analgesic overuse syndrome related to chronic narcotic use.[129] In his independent medical examination report of January 2, 2013, Dr. Jaffe explained that he could not discern how much of Hollup's subjective complaints of memory and concentration problems were due to his fairly large dose of Percocet.[130] These repeated references in the medical records illustrate that medication overuse was a substantial, contributing cause of Hollup's increased psychiatric symptoms.

With respect to Hollup's opiate dependence, Dr. Rater concluded there were no medications that Hollup was taking that was medically necessary for his accident related

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[122] Ex. 20 (03/03/08; 04/14/08).

[123] Ex. 35.

[124] Ex. 20 (9/23/04).

[125] Ex. 21 (10/15/04).

[126] Ex. 23.

[127] Ex. 24.

[128] *Id.*

[129] Ex. 6.

[130] Ex. 38.

psychiatric problems. He explained that Hollup was receiving opiates for a longer period of time and in higher doses than originally assessed. He noted Hollup had multiple prescribers, which is "a red flag for opiate dependence," and indicated that as recently as August 2004, the medical reports reflect issues with substance abuse. Hollup continued to use narcotics despite learning that they could worsen his headaches and mood problems. Dr. Rater concluded that Hollup suffered from opiate dependence and used his head injury as rationale for opiate requests.[131] As noted earlier, Dr. Rater stated that Hollup's problems of irritability and conflict were explained by his marital conflict and substance abuse, rather than the head injury.

Besides the references made by Dr. Rater, the medical records contain many other references of Hollup's requests for opiates using his head injury as a basis of his pain complaints. Dr. Smith noted concerns with Hollup's use of narcotics. He even declined prescribing them to him in February 2005 and June 2006 when requested by Hollup. Towards the end of his treating relationship with Hollup, Dr. Smith even recommended substance abuse treatment.[132] In June 2005, Dr. Vydrin gave Hollup another prescription for Vicodin, but warned him not to use more than once or twice a week.[133] After being treated for a fall in August 2005, Hollup was prescribed Percocet for knee pain.[134] Hollup was still taking Vicodin in September 2005.[135] As of December 21, 2005, Hollup reported taking one or two Vicodin or Percocet daily.[136] After complaining to Dr. Vydrin in January 2006 that Vicodin was losing its efficacy, Hollup requested and was prescribed Percocet. In the following month, February 2006, he sought additional pain medication from Dr. Groves in Urgent Care. Despite being prescribed Percocet the month before and having a history of drug abuse, Dr. Groves prescribed additional Vicodin.[137] Dr. Vydrin prescribed more Percocet in April

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[131] Exs. 11, 35. In the DIA hearing decision, the Administrative Judge listed medical record citations from Dr. Rater showing a pattern of drug seeking behavior. This was discussed earlier in detail.

[132] Ex. 20 (2/2/05, 6/28/06).

[133] Ex. 24 (06/08/05).

[134] Ex. 27 (08/23/05).

[135] Ex. 24 (09/07/05).

[136] Ex. 20.

[137] Ex. 29 (02/22/06).

2006.[138] Dr. Groves prescribed additional Vicodin in May 2006 during an Urgent Care visit.[139] Between November 2006 and September 2007, Dr. Vydrin continued to prescribed Percocet.[140] Throughout 2008, the medical reports reflect use of Vicodin, Percocet, or Oxycodone even in the absence of objective neurological deficits and physical examination findings. In 2013, Hollup was still using Percocet.[141] As of November 2014, the psychiatric medical panel indicated that Hollup remained on Oxycodone. There were no objective findings on physical and neurological examinations or radiological studies for use of pain medication.[142]

The medical records also show that Hollup functioned poorly without a structured life. Dr. Cutler, who examined Hollup on November 14, 2005 at the request of his attorney, found that he was unable to function without the structure of work.[143] In October 2006, Hollup expressed to Dr. Dowd that he was distressed due to lack of work. Despite this and the fact that he managed his psychiatric symptoms better with the structure of work, he did not want to return to work and had consistently sought medical excuses from his doctors to remain out of work.[144] According to the psychiatric medical panel, Hollup did not try to work in any capacity following the head injury.[145] He even pursued Workers' Compensation benefits almost five years after the head injury.[146]

The medical references above highlight that family and marital discord, medication overuse and opiate dependence, financial stressors, and lack of a structured life were significant contributing causes of Hollup's psychiatric symptoms. Accordingly, Hollup has not met his burden to show that the head injury of September 2004 was the predominant cause of his psychiatric disability.

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[138] Ex. 24.

[139] Ex. 30.

[140] Ex. 24.

[141] Ex. 38.

[142] Ex. 15.

[143] Ex. 19.

[144] Ex. 20 (10/26/06).

[145] Ex. 15.

[146] Ex. 11. A DIA Administrative Judge held a hearing on August 25, 2009 regarding his application for permanent and total incapacity benefits, commencing June 5, 2008.

5. *Psychiatric medical panel certification.*

The DALA magistrate relied heavily on the affirmative certification of the psychiatric medical panel to grant Hollup accidental disability retirement benefits. Where the psychiatric medical panel lacked pertinent facts or applied an erroneous standard, its affirmative certification to the questions of disability, permanence, and causation cannot be relied upon in granting benefits. *Retirement Board of Revere v. Contributory Retirement Appeal Bd.*, 36 Mass. App. Ct. 99, 106 (1994) (a medical panel's certificate responses can be overcome upon proof that the panel lacked pertinent facts or employed an erroneous standard). To establish a prima facie case for accidental disability retirement benefits, there must be "sufficient evidence that, if unrebutted and believed, would allow a factfinder to conclude that [the petitioner] suffered a permanent disability based on [a personal injury] sustained while performing her [work duties]." *Lowell v. Worcester Retirement Bd.*, CR-06-296 (DALA 2009, no CRAB opinion).

Here, ten years after the fall, the psychiatric medical panel found causation in the affirmative based on Hollup's statements, which varied over time or were inaccurate. It also lacked pertinent facts regarding other causes of Hollup's psychiatric symptoms in making its findings. The account of the head injury and facts regarding Hollup's medical history and psychiatric treatments can affect the psychiatric medical panel's opinion on disability.

As discussed in detail in the DIA hearing decision, the extensive medical record is very instructive regarding Hollup's varying accounts of the head injury of September 14, 2004. Through the years, the account of the accident became more dramatic with the passage of time. Initially, the ED report on the date of the accident indicated that Hollup denied loss of consciousness, which was corroborated by a normal Glasgow score and normal MRI and MRA scans. Later, Hollup described loss of consciousness in varying lengths of time from brief to about five minutes in duration. The speed of the garbage truck also changed over time from speeds of 30 mph to 40 mph and veering suddenly. Even the circumstances of the landing and fall were different. The First Report of Injury filed by the employer in September 2004 indicated that Hollup stepped into a rut on the street, and he fell backwards into a brick retaining wall, hitting the back of his head resulting in eight staples. According to Dr. Smith, Hollup explained that he jumped off the truck while it was moving, as a method that he and others used to do a lot of work in a little amount of time. In November 2004, he reported to

Dr. Savla that as he tried to come off the moving truck and holding one hand to the handle, his left foot got caught in a pothole. He fell and struck his head against the road. In March 2007, Hollup reported to Dr. Cutler that he was hanging on the back of the truck when the driver hit a rut in the road. He was thrown off the truck and hit a retaining wall. During a subsequent examination with Dr. Savla in March 2007, Hollup reported that he was riding on the back of the truck, which was traveling at around 40 mph, and fell with the impact over the back part of the brain resulting in a left occipital laceration. He also had loss of consciousness. During the first medical panel interview in March 2008, Hollup reported that he fell from the back of a sanitation truck when it hit a bump in the road. He recalled landing on his feet, but had no recollection until the ambulance ride to the ED. He described being amnestic of the fall and unconscious for several minutes. According to Vincent Birbiglia, M.D., who examined him on September 17, 2009, Hollup reported that he lost his balance and was thrown off to the ground when the truck veered suddenly. As he was trying to catch up to the truck, which was pulling away, he slipped, fell, and struck his head, sustaining a laceration requiring eight staples.[147] With respect to his reports of loss of consciousness, the DALA magistrate determined that the medical records substantiated this claim. However, the medical records from UMMC completed on the day of the fall indicated Hollup denied loss of consciousness. This was supported by a normal Glascow coma score and negative findings from MRIs. The disparities regarding loss of consciousness and the details of the accident are not inconsequential as stated by the DALA magistrate. These facts are pertinent in addressing the severity of Hollup's injury and the cause of disability.

Although the psychiatric medical panel found causation in the affirmative, the record points to other causes that significantly contributed to Hollup's psychiatric disability, namely family and marital discord, financial stressors, medication overuse and opiate dependence, and lack of a structured life. These causes were addressed in detail above. These pertinent facts were not conveyed to the psychiatric medical panel or were inaccurately reported or withheld by Hollup.[148] Therefore, we decline to rely on the psychiatric medical panel's opinion on causation.

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[147] Ex. 11.
[148] Ex. 11, 15, 20, 24, 27, 29, 30, 35.

Here, the circumstances that surround the accident and Hollup's medical history and psychiatric treatments are all pertinent issues, which affect a medical panel's findings regarding disability. We are not persuaded by the psychiatric medical panel's opinion, which found causation in the affirmative. The medical panel lacked pertinent facts in rendering an opinion, and its findings were based on inaccurate statements made by Hollup. Its opinion does not establish a prima facie case for accidental disability retirement benefits. Following *Revere and Lowell*, we decline to rely on the psychiatric medical panel's determination that the head injury of September 2004 was the natural and proximate cause of Hollup's psychiatric disability.

6. *Medical opinions of Drs. Smith, Kirsch, Cutler, Salva, Braverman, and Vydrin.*

The DALA magistrate relied on the medical opinions of Drs. Smith, Kirsch, Cutler, Salva, Braverman, and Vydrin to support her decision to grant accidental disability retirement benefits. She determined that their medical opinions established that the head injury of September 2004 was the proximate cause of Hollup's disability. After a review of the record, we do not agree with the DALA magistrate.[149]

The DALA magistrate relied on Dr. Smith's opinion in granting accidental disability retirement benefits. However, his opinion does not establish a prima facie case to grant accidental disability retirement benefits. Hollup was initially referred to Dr. Smith in September 2004 by his therapist at the anger management program. This did not appear to be in response to the head injury, but from assessments she made from his participation in the program. Dr. Smith initially evaluated Hollup nine days after the head injury and determined that he did not present with any classic depressive episode, but noted a history of ADHD with remote history of Ritalin use. Medication therapy was initiated with a large gap in treatment between February 2005 and December 2005. Dr. Smith ruled out a mental disorder NOS due to head trauma on December 27, 2005. When he last treated Hollup on June 26, 2006, he found that Hollup had some low level paranoia due to his persistent questioning of his thoughts of him. While Hollup believed his anger was due to the head injury, Dr. Smith felt this was not completely clear from the history. He wrote that he had "ask[ed] [Hollup] to

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[149] The recent Rule 1:28 decision *Morse*, 2019 WL 7286919, reiterated that "CRAB may reject expert opinions on the basis of its own review of the entirety of the record (including medical and nonmedical evidence). *Narducci*, 68 Mass. App. Ct. at 135.

consider that his anger may not be attributable to his accident, something which [he] believe[d] that [Hollup] recognize[d] on one level but on another was not sure of [his] motivation of pointing out."[150] Dr. Smith's statements clearly demonstrate that he did not find a clear causal connection between the head injury and Hollup's psychiatric disability. Consequently, Dr. Smith's opinion does not support the DALA decision that Hollup proved by a preponderance of the evidence that his psychiatric disability was caused by the head injury.

The DALA magistrate also relied on the opinion of Dr. Kirsch. Initially, Dr. Kirsch explained on October 4, 2006 that while Hollup's psychiatric history was significant enough to be disabling and likely to be permanent, he could not assign causation in his capacity as Hollup's treating physician.[151] It was more than seven years later in his report of December 20, 2013 that Dr. Kirsch later concluded Hollup was totally and permanently disabled as a result of the September 2004 accident. Dr. Kirsch failed to explain how the head injury aggravated his pre-existing psychiatric conditions.[152] Dr. Kirsch also completed the Physician's Statement for Hollup's accidental disability retirement benefit claim. He answered all three questions of disability, permanence, and causation in the affirmative, noting that the job-related injury caused his psychiatric disability.[153] The DALA magistrate found his opinion persuasive in granting accidental disability retirement benefits. Her findings are entitled to some deference. *Vinal v. Contributory Retirement Appeal Bd.*, 13 Mass. App. Ct. 85, 100-101 (1982). However, where the physician's statement rests on facts that are contradicted by the complete medical record or that are not credited by the magistrate, it lacks foundation. *See Brommage's Case*, 75 Mass. App. Ct. 825, 827-828 (2009). Here, the medical record shows that Hollup provided inaccurate statements regarding the accident, his treatments, history of aggressive behavior and his opiate dependence. Hollup downplayed his anger problems, reporting that they were mostly verbal outbursts. He also attributed his increased aggression to his head injury. Dr. Kirsch relied on those facts and statements in reaching his conclusions. In *Lowell v. Worcester Retirement Bd.*, CR-06-296 (DALA 2009,

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[150] Ex. 20.

[151] Ex. 33 (10/4/06).

[152] Ex. 39.

[153] Ex. 13.

no CRAB opinion), the DALA magistrate described a prima facie case for accidental disability retirement benefits as "sufficient evidence that, if unrebutted and believed, would allow a factfinder to conclude that [the petitioner] suffered a permanent disability based on [a personal injury] sustained while performing her [work duties]." We re-affirmed in *Blau v. Norfolk County Retirement Bd.*, CR-10-159 (March 2013), and stated that a prima facie case must rest on "competent evidence." Thus, a physician's statement that lacks sufficient foundation by omitting details or resting on inaccurate facts would not support a prima facie case. "Nothing in *Lowell* suggests that an improper or incorrect physician's statement must be accepted." *Id.* Dr. Kirsch's opinion regarding causation lacks sufficient foundation. Moreover, there is substantial evidence in the record pointing to other significant contributing causes of Hollup's psychiatric disability, including Dr. Kirsch's own treatment notes. His notes state that Hollup was susceptible to decompensation by changes in his wife's thinking and behavior. Dr. Kirsch determined this to be a deficit in Hollup's mood regulation and impulse control ability. There is nothing in his reports showing the head injury to be the proximate cause of Hollup's increased psychiatric symptoms. Accordingly, we decline to rely on Dr. Kirsch's opinion.

The DALA magistrate also found Dr. Cutler's opinion persuasive in granting accidental disability retirement benefits. Dr. Cutler was asked by Hollup's attorney to provide multiple psychiatric examination reports in November 2005, March 2007, July 2007, June 2008 and September 2008. During each of these evaluations, Hollup gave varying accounts of the accident, including his loss of consciousness, the speed of the truck, and the description of the fall itself. Dr. Cutler first diagnosed Hollup with a pain disorder associated with both psychological factors and a general medical condition; bipolar disorder; and personality disorder. Later in March 2007, Dr. Cutler included diagnoses of ADHD and a major depressive disorder. In November 2005 and September 2008, Dr. Cutler noted Hollup appeared well dressed. He did not observe Hollup to be disheveled. His assessment and conclusions of causation were based on Hollup's statements and the medical records provided by Hollup's attorney. Noticeably absent from his record review were medical records from Hollup's treating psychiatrists and psychologist, despite indicating in his reports that Hollup

was receiving psychiatric treatment and psychotherapy.[154] Those medical records contain pertinent facts regarding Hollup's psychiatric condition and evidence of other significant contributing causes of his increased psychiatric symptoms. Thus, Dr. Cutler's opinion was not based on competent evidence because he lacked pertinent facts and rendered an opinion based on inaccurate statements. *Brau, supra.* Accordingly, we decline to rely on his opinion regarding causation.

The DALA magistrate also relied on Dr. Savla's opinion in granting Hollup's accidental disability retirement benefits. Dr. Savla conducted independent medical examinations at the request of Hollup's employer and his attorney. Each of Dr. Savla's three reports were favorable to the requesting party. Specifically, in his first report for Hollup's employer dated November 23, 2004, Dr. Savla concluded, as did the first medical panel, that Hollup's headaches were due to muscle tension or medication overuse and that he was able to return to work. However, upon request by Hollup's attorney, Dr. Savla in March 2007 and August 2008 concluded that Hollup was not able to work in his sanitation job due to headache and mood disorder and opined that the symptoms were causally related to the September 2004 fall. He did not discuss the change in his opinion from his initial report of November 2004.[155] His conclusory statements in his reports of March 2007 and August 2008 provided little support that the head injury was the proximate cause of Hollup's psychiatric disability in light of the substantial medical records pointing to other significant contributing causes. The doctor's opinions appear to have been made for the parties requesting the evaluation and were also based on Hollup's own statements, which contained many disparities and inaccuracies. Consequently, Dr. Savla's opinion does not establish a prima facie case for granting accidental disability retirement benefits.

The DALA magistrate also found Dr. Braverman's opinion persuasive. In his independent psychiatric examination report of January 2006, Dr. Braverman concluded that the work injury was the predominant and significant contributing cause of Hollup's psychiatric disability.[156] However, Hollup reported his primary disability to be headaches, but this was precluded by the negative certification of the first medical panel. During that

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[155] Ex. 36.

[156] Ex. 28.

examination, Hollup made inaccurate statements regarding his treatment, history of aggressive behavior, and the work accident, which fail to support his opinion. Other than the violent incident of 1987, he failed to disclose the many incidences of aggressive behavior towards his girlfriend, his wife, and other individuals through the years, including the fight one month before the head injury and his history of incarceration for his violent acts. He denied that the road rage incident of June 2003 resulted in any physical confrontation, but the police report and other medical records reveal otherwise. He denied history of alcohol or drug abuse and abuse of prescription drugs, yet the medical records demonstrate evidence of opiate dependence. Dr. Braverman also indicated that he did not review psychiatric treatment records from Hollup's treating sources. Here, where an opinion is not based on competent evidence, the opinion fails to establish a prima facie case for accidental disability retirement benefits. *See Brau, supra. Lowell*, CR-06-296 (DALA 2009, no CRAB opinion). Therefore, we also decline to rely on Dr. Braverman's opinion.

The DALA magistrate also relied on the opinion of Dr. Vydrin in granting accidental disability retirement benefits. Dr. Vydrin, a neurologist, treated Hollup for his headaches with narcotic pain medications. He opined in November 2006 that he was disabled based on a combination of residuals of his previous work-related injury and psychiatric condition, but then in March 2007, Dr. Vydrin concluded that he remained disabled due to excessive drowsiness and lots of medication.[157] Dr. Vydrin's opinion regarding Hollup's disability cannot be used to establish disability based on a neurological disorder as it was precluded by the negative certification of the first medical panel. Further, since he does not specialize in Psychiatry, Dr. Vydrin is not in the best position to render an opinion on disability based on a psychiatric disorder. Accordingly, we decline to rely on Dr. Vydrin's opinion.

The DALA magistrate based her decision partly on the opinions of the above doctors. Those opinions, however, do not establish a prima facie case for accidental disability retirement benefits. When reviewing the record as a whole, Hollup has not proven by a preponderance of the evidence that his head injury of September 14, 2004 was the proximate cause of his psychiatric disability.

Conclusion

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[157] Ex. 24.

The DALA decision is reversed. Hollup is not entitled to accidental disability retirement benefits.

SO ORDERED.

CONTRIBUTORY RETIREMENT APPEAL BOARD

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Date: January 8, 2020