U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RONALD B. JACKSON and U.S. POSTAL SERVICE,
MAIN POST OFFICE, Chicago, IL

Docket No. 00-2776; Submitted on the Record;
Issued April 8, 2002

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether the Office of Workers' Compensation Programs properly determined appellant's loss of wage-earning capacity, based on his actual earnings; and (2) whether the Office properly denied appellant's request for authorization for additional back surgery.

The case has been on appeal previously.[1] The Board noted that appellant sustained a back injury on March 25, 1996 and underwent surgery for decompressive lumbar laminectomy at L3-4, removal of a herniated disc at L4-5 and foraminotomies at L3-4, L4-5 and L5-S1. The Office accepted appellant's claim for a herniated L4-5 disc and paid temporary total disability compensation. Appellant subsequently became employed as a community service officer. The employing establishment offered appellant a modified rehabilitation clerk position, which he refused. The Office terminated appellant's compensation for refusal of suitable work. The Office also found that appellant had received a $12,877.43 overpayment in compensation because he had refused suitable work and had worked in a position from March 3, 1996 to March 27, 1997, which did not reasonable reflect his wage-earning capacity. The Board found that the Office improperly determined that appellant had refused suitable work because it had not fully considered whether appellant's employment as a community service officer fairly and reasonably represented his wage-earning capacity and because the medical evidence on appellant's physical restrictions was inconsistent. The Board found that the Office properly concluded that appellant received an overpayment in compensation because he was worked while receiving temporary total disability compensation. The Board held, however, that the Office improperly found that appellant was at fault in creation of the overpayment. The Office concluded that appellant knew or reasonably should have known that the community service officer position did not reasonably present his wage-earning capacity. The Board held that this basis for concluding appellant was at fault was improper because it did not fit under the criteria

[1] Docket No. 97-2524 (issued December 13, 1999).

set forth in the applicable regulation.[2] The Board therefore reversed the Office's decision terminating appellant's compensation for refusing suitable work. The Board affirmed the Office's decision that appellant had received an overpayment in compensation but set aside the finding that appellant was at fault in the creation of the overpayment.

In an April 7, 2000 decision, the Office found that appellant's position as a community service officer fairly and reasonably represented his wage-earning capacity and reduced his compensation. Appellant requested reconsideration. In an August 17, 2000 merit decision, the Office denied modification of the April 7, 2000 decision. In an August 31, 2000 decision, the Office denied appellant's request for authorization for additional back surgery.

The Board finds that the Office properly determined appellant's wage-earning capacity based on his actual earnings as a community service officer.

Under section 8115(a) of the Federal Employees' Compensation Act, wage-earning capacity is determined by the actual wages received by an employee if the earnings fairly and reasonably represent his wage-earning capacity.[3] Generally, wages actually earned are the best measure of wage-earning capacity and in the absence of evidence that they do not fairly or reasonably represent the injured employee's wage-earning capacity, will be accepted as such measure.[4] Office procedures direct that a wage-earning capacity determination based on actual earnings be made following 60 days of employment.[5] The procedures provide for a retroactive determination where an employee has worked for at least 60 days and the work stoppage following that date was not due to the employment-related condition.[6]

Appellant began working as a part-time community service officer on October 15, 1995 and full time on March 25, 1996. He stopped working on March 27, 1997. The Office determined, on the basis of appellant's actual earnings, that he had a 53 percent loss of wage-earning capacity. As appellant worked for a year, his earnings as a community service officer can be used to determine his wage-earning capacity unless it could be established that his work stoppage was due to the employment-related condition.

In a May 30, 1997 report, Dr Raghu Singh, a neurosurgeon, stated that a computerized tomography (CT) scan of the lumbar region showed severe spinal stenosis at L4-5 and, to a lesser extent, at L3-4, associated with large bony masses posteriorly, possibly related to prior surgery. Dr. Singh stated that there was no significant change from a September 1993 CT scan.

The Office referred appellant to Dr. Julie Wehner, a Board-certified orthopedic surgeon, for an examination and second opinion. In an August 22, 1997 report, Dr. Wehner stated

[2] 20 C.F.R. § 10.320(b) (1997).

[3] 5 U.S.C. § 8115(a); *see Elbert Hicks*, 49 ECAB 283 (1998).

[4] *Todd Harrison*, 49 ECAB 571 (1998).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reemployment: Determining Wage-Earning Capacity*, Chapter 2.814.7(a) (December 1993).

[6] *Id.*, Chapter 2.814.7(e).

appellant had no significant paraspinal examination. She noted that appellant was limited in the motion of his back and had a mildly antalgic gait pattern. Dr. Wehner reported that hip motion on the right side produced severe groin and hip pain. She indicated that a July 19, 1996 magnetic resonance imaging (MRI) scan showed degenerative changes at L1-2, posterolateral indentations on the thecal sac at L2-3 and marked facet hypertrophy with moderately severe central stenosis. Dr. Wehner noted a Grade I spondylolisthesis at L4-5 which "did not appear unchanged from before" and moderate spinal stenosis. At L5-S1, appellant had mild facet hypertrophy with no significant stenosis. Dr. Wehner diagnosed a chronic pain syndrome with a postlaminectomy syndrome. In an accompanying work capacity report, she stated that appellant should limit his standing to no more than 2 hours and should not perform any twisting, bending or lifting over 20 pounds. Dr. Wehner indicated that, with those restrictions, appellant could work eight hours a day.

Appellant was hospitalized from January 31 to February 5, 1998 with admitting diagnoses of pancreatitis, status post hip replacement surgery, hypertension and cardiac arrhythmia with an episode of atrial fibrillation.

In a July 2, 1998 report, Dr. Wehner stated that appellant had improved after undergoing bilateral hip replacement and resolving pancreatitis. She noted that appellant used a cane on an intermittent basis. Dr. Wehner indicated that appellant had undergone a large weight loss but was currently able to gain weight. She reported that appellant had decreased knee and ankle reflexes bilaterally but a normal motor examination. Dr. Wehner noted on examination that a thinned area over the coccyx and distal sacral area was tender. She related that a March 1997 MRI scan showed severe central stenosis at L3-4 and somewhat at L4-5 with spondylolisthesis at L4-5. Dr. Wehner commented that the L4-5 level appeared to be work related because it was the site of appellant's previous surgery and he apparently had developed restenosis at the site of the surgery.

In a March 2, 2000 report, Dr. Christopher J. Cascino, a neurosurgeon stated that an examination of appellant showed that straight leg raising produce low back pain but no pain radiating down the legs. Dr. Cascino reported that the range of motion in the hips was normal, as was the motor examination of the muscles of the legs. He noted that appellant had decreased pinprick sensation in the right L4-5 and S1 dermatomes, with the most significant numbness in the right L5 dermatome. Dr. Cascino also noted decreased knee and ankle reflexes bilaterally.

In a June 21, 2000 report, Dr. Singh indicated that a lumbar myelogram of appellant showed a mild extradural defect on the right at L3-4, a moderate, bilateral extradural defect at L4-5 and evidence of a Grade I spondylolisthesis at L4-5. He noted that no definite spinal stenosis was evidence at L5-S1. A CT scan taken postmyelogram showed mild spinal stenosis at L2-3 due primarily to bilateral facet and ligamentum flavum hypertrophy. At L3-4, appellant had a mild generalized annular bulge but no definite evidence of disc herniation, a moderate spinal stenosis and bilateral narrowing of the neural foramina, more prominent on the right than the left. At L4-5, the CT scan showed a Grade I spondylolisthesis and postoperative changes. Dr. Singh noted appellant had prominent bony hypertrophic changes bilaterally. He found evidence of an annular bulge but no definite disc herniation. Dr. Singh indicated that appellant had a moderate spinal stenosis and narrowing of the bilateral neural foramina. At L5-S1,

appellant had postoperative changes with bony hypertrophic more prominent on the right than the left. There was no evidence of disc herniation or spinal stenosis at that level.

Drs. Wehner, Cascino and Singh noted that appellant had postoperative changes at the L4-5 level. Dr. Wehner specifically related the changes to appellant's employment injury because the initial surgery was performed as a result of the employment injury. Drs. Wehner and Cascino indicated that appellant had decreased knee and ankle reflexes and decreased sensation in the legs. None of the physicians specifically stated that appellant's condition had deteriorated due to the effects of the employment injury and resulting surgery. Furthermore, while Dr. Wehner stated in her initial report that appellant could work eight hours a day with restrictions, none of the physicians discussed whether appellant was unable to perform the duties of a community service officer after March 27, 1997 and, if he was unable to work, whether the inability to work was a result of the accepted employment injury. Appellant therefore has not met his burden of establishing that his ability to earn the actual wages of a community service officer had ceased due to the employment injury. The Office's determination that appellant's actual earnings fairly and reasonably represented his wage-earning capacity has not been rebutted.

The Board further finds that the Office did not abuse its discretion in denying appellant's request for additional back surgery.

Section 8103 of the Act states:

> "The United States shall furnish to an employee who in injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation."[7]

In interpreting section 8103, the Board has long recognized that the Office, acting as the delegated representative of the Secretary of Labor, had broad discretion in approving services under the Act.[8] The Office has the general objective of ensuring that an employee recovers from his injury to fullest extent possible in the shortest period of time. The Office therefore has broad administrative discretion in choosing means to achieve this objective.

In a June 11, 1997 note, Dr. Singh recommended a decompressive lumbar laminectomy at L3-4 and L4-5, indicating that appellant was in great pain. In a July 1, 1997 memorandum, Dr. Nabil F. Angley, a Board-certified orthopedic surgeon and Office consultant, noted that appellant had spinal stenosis at L4-5 which was compressing the thecal sac. Dr. Angley commented that the compression must be decompressed surgically to relieve appellant's symptoms. He noted, however, that the operation could lead to weakness and further instability in the spine. Dr. Angley indicated that, if spondylolisthesis already existed, a laminectomy

[7] 5 U.S.C. § 8103(a).

[8] *James R. Bell*, 49 ECAB 642 (1998).

would aggravate the instability in the spine and worsen the spondylolisthesis. He recommended a second opinion.

Dr. Wehner was asked by the Office to address whether appellant should undergo additional surgery. In her August 22, 1997 report, she noted the recommendation for a decompressive lumbar laminectomy at L3-4 and L4-5. Dr. Wehner indicated that a significant portion of appellant's pain came from the rotation of his hips. She recommended that appellant undergo hip replacement surgery, which she stated was not work related, before he considered additional back surgery. Dr. Wehner stated that hip surgery relieved a considerable portion of appellant's pain, then it was possible he would find the back pain would be more tolerable and therefore would be able to function without pursuing fairly radical surgery. She commented that surgery would not be advantageous to appellant at that time because he had lost weight recently and appeared to have many medical problems. Dr. Wehner recommended an extensive work up to rule out underlying problems, such as a possible primary tumor or metastatic disease to the back, before back surgery could be considered.

In an April 17, 1998 note, Dr. Singh repeated his recommendation of back surgery. In a May 14, 1998 memorandum, Dr. Angley indicated that several questions needed to be answered before back surgery could be authorized. He recommended that appellant be referred to Dr. Wehner again for further evaluation.

In her July 2, 1998 report, Dr. Wehner noted that appellant's pancreatitis apparently had been resolved and his weight loss appeared to have been treated so that appellant was now gaining weight. She stated, however, that appellant remained a poor candidate for spinal surgery because of the multiple operations on his back and his ill health. Dr. Wehner recommended that appellant wait at least a year before considering further surgery on his back. She suggested that appellant undergo physical therapy, including water exercise and weightlifting, to build up his strength. Dr. Wehner indicated that appellant's tailbone pain seemed to be a sufficient cause of his pain, which would not improve with surgical intervention. She stated that the spinal stenosis seen on x-ray did not appear currently to be a limiting problem. Dr. Wehner indicated that, if appellant was symptomatic in one year, surgery could be contemplated. She stated that the surgery would be an L3-4 and L4-5 decompression, with fusion to treat the spondylolisthesis.

Dr. Singh continued to recommend surgery. The Office requested a second opinion from Dr. Cascino. In his March 2, 2000 report, Dr. Cascino noted that appellant had radiating right leg symptoms in the L5 dermatome since 1986 but had no weakness in that distribution. He indicated that, since appellant only had numbness in the leg, he would not recommend surgery because of the long-standing nature of the right leg symptoms. Dr. Cascino commented that the spinal stenosis seen on the MRI scan did not cause neurogenic claudication and therefore was not clinically relevant. He indicated that the spondylolisthesis could be responsible for appellant's low back pain. Dr. Cascino stated, however, that he would only consider performing a posterior lumbar fusion if there was movement on flexion/extension x-rays.

In a June 27, 2000 note, Dr. Singh again stated that appellant needed surgery. In an August 17, 2000 note, he indicated that a physical therapist reported appellant was beginning to experience bowel and bladder symptoms.

In an August 24, 2000 memorandum, Dr. Mark Stewart, an Office medical adviser, reviewed Drs. Cascino and Singh's reports. Dr. Stewart stated that appellant reported low back and right leg radiating pain. He indicated that no bowel or bladder problems were reported. Dr. Stewart noted that physical examination revealed normal motor function. He commented that appellant had subjective, objective and imaging studies consistent with a degenerative Grade I spondylolisthesis at L4-5. Dr. Stewart stated that Dr. Singh had recommended exploration at L3-4 and L4-5 while Dr. Cascino recommended a fusion of the lumbar spine at L4-5. Dr. Stewart indicated that he agreed with Dr. Cascino and would not recommend exploration at L3-4 and L4-5. He noted that appellant did not want a fusion but opined that a fusion would give appellant the most relief from pain.

Dr. Singh continually stated that appellant required further back surgery. However, he did not submit any detailed report setting forth his reasons for recommending further back surgery on appellant. Dr. Singh only noted in an August 17, 2000 note that appellant was reportedly having bowel and bladder problems. Drs. Wehner and Cascino declined to recommend further surgery on appellant's back. Dr. Wehner stated that appellant needed to have hip replacement surgery, which was performed. She then recommended physical therapy to build appellant's strength before further surgery could be considered. Dr. Wehner stated that appellant should wait a year before determining whether appellant's back symptoms persisted to the point that back surgery would be necessary. There is no indication in the record that appellant received such physical therapy. Dr. Cascino stated that he would not recommend surgery to correct the numbness in appellant's right leg because it was long-standing. He indicated that he would not recommend a fusion unless x-rays showed movement in appellant's spondylolisthesis. There is no indication in the record that x-rays showed movement in appellant's spondylolisthesis. Therefore, the medical evidence does not establish a need for surgery on appellant's back. Dr. Singh's requests for surgery do not contain any detailed rationale for additional back surgery. His reports, therefore, do not have sufficient probative weight to conflict or overcome the probative value of the reports of Drs. Wehner and Cascino who reported that back surgery was not necessary or not advisable.[9] As the only limitation on the Office's authority is reasonableness, abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from known facts.[10] The medical evidence of record shows that the Office had reasonable medical support for its conclusion that additional back surgery on appellant was not warranted. The Office's decision to refuse to authorize surgery, therefore, was not an abuse of discretion.

[9] Dr. Stewart stated that he would not recommend exploratory surgery at L3-4 and L4-5 as recommended by Dr. Singh. He did indicated that he would support fusion surgery as recommended by Dr. Cascino, who, however, stated that he would support fusion surgery only if movement was seen on motion of the spondylolisthesis. The record does not show whether such x-rays were ever performed. Therefore, Dr. Stewart's report is based on a faulty assumption and, as a result, has little probative value.

[10] *Daniel J. Perea*, 42 ECAB 214 (1990).

The decisions of the Office of Workers' Compensation Programs dated August 30 and 17, and April 7, 2000 are hereby affirmed.

Dated, Washington, DC
April 8, 2002

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member