U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DAVID L. EASTWOOD and DEPARTMENT OF JUSTICE,
FEDERAL CORRECTIONAL INSTITUTE, Oakdale, LA

Docket No. 02-461; Submitted on the Record;
Issued February 6, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly determined that appellant could perform the duties of a chauffeur and, therefore, had a 67 percent loss of wage-earning capacity.

On December 12, 1993 appellant, then a 35-year-old correctional officer, was walking at work when his left knee buckled and he fell.[1] He worked intermittently thereafter until he stopped working in September 1994. The employing establishment removed him from his position in January 1995. The Office accepted appellant's claim for a torn medial meniscus. Appellant underwent arthroscopic surgery on January 12, 1994. Dr. Dennis Walker, a Board-certified orthopedic surgeon, reported that the surgery showed that the menisci were intact but indicated that appellant had multiple large chondral fractures of the patellar groove, multiple large loose bodies and a chondral fracture of the lateral tibial plateau. The Office paid appellant temporary total disability compensation for the periods he did not work.

In a January 3, 2001 decision, the Office found that appellant could perform the duties of a chauffeur and, therefore, had a 67 percent loss of wage-earning capacity. The Office reduced appellant's compensation effective December 31, 2000. In an April 11, 2001 letter, appellant requested reconsideration. In an August 31, 2001 merit decision, the Office denied appellant's request for modification of the prior decision.

The Board finds that the Office improperly found appellant could perform the duties of a chauffeur and therefore had a 67 percent loss of wage-earning capacity.

[1] The original claim form and other records pertaining to prior injuries and subsequent injuries to the left knee and the right knee are not contained in the record submitted on appeal. However, in light of the issue in this case, those records are not essential for purposes of the Board's review of this case.

Wage-earning capacity is a measure of the employee's ability to earn wages in the open labor market under normal employment conditions, based on the nature of the employee's injuries and the degree of physical impairment, employment, age, vocational qualifications and the availability of suitable employment.[2] Accordingly, the evidence must establish that jobs in the position selected for determining wage-earning capacity are reasonably available in the general labor market in the commuting area in which the employee lives. In determining an employee's wage-earning capacity, the Office may not select a makeshift or odd lot position or one not reasonably available on the open labor market.[3]

In a May 28, 1997 work capacity evaluation form, Dr. Walker stated that appellant should limit kneeling, standing, bending, twisting, reaching, lifting, walking, climbing and carrying. He stated that appellant should not lift more than 10 pounds and should avoid kneeling and climbing. Dr. Walker noted that appellant could bend and twist as long as he was seated. He concluded that appellant could perform sedentary work, four hours a day.

In a July 27, 1997 memorandum, an Office claims examiner indicated that the position of chauffeur was a light-duty position that required the ability to lift up to 20 pounds occasionally and 10 pounds frequently. The job did not require climbing, kneeling or crawling and required occasional stooping or crouching. The position required a vocational background of 30 days to 3 months. The claims examiner indicated that the job was performed in sufficient numbers so as to be considered reasonably available within appellant's commuting area.

In a September 10, 1999 letter, the Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Samir Ebead, a specialist in reconstructive orthopedics, for an examination and second opinion on the extent of his disability. He indicated that examination of the legs showed no muscle wasting of the muscle groups of the legs. Dr. Ebead stated that appellant had normal range of motion of both knees and several tests of the knees were negative. He reported that x-rays showed mild arthritic changes of the knees. Dr. Ebead concluded that appellant showed residual effects of his employment injuries but the effects were not disabling. He stated that appellant conceivably had active chondromalacia. Dr. Ebead indicated that appellant could engage in a light-duty job and perhaps more than light duties with some modification. He concluded that appellant could perform the duties of a chauffeur and car delivery. Dr. Ebead noted that appellant drove to the medical appointment and did not see any impairments to appellant's ability to drive. In an accompanying work evaluation form, he indicated that appellant could sit 8 hours a day, walk, stand, push or pull 3 to 4 hours a day, lift 1 to 2 hours a day with a maximum lifting of 25 pounds, occasional squatting and climbing, very occasional lifting and no limit on reaching, reaching above the shoulder, twisting or repetitive motions. Dr. Ebead commented that he did not advise that appellant operate equipment that required both feet, such as forklifts and bulldozers.

Appellant's treating physician referred appellant to Dr. Stephen Flood, a Board-certified orthopedic surgeon. In a December 16, 1999 report, Dr. Flood stated that appellant had no signs

[2] *See generally*, 5 U.S.C. § 8115(a); A. Larson, *The Law of Workers' Compensation* § 57.22 (1989).

[3] *Phillip S. Deering*, 47 ECAB 692 (1998).

of atrophy or altered heat or skin except for surgical scars. He found no effusion in either knee. Dr. Flood stated that appellant had no instability in his knees. He noted diffuse medial and lateral joint line tenderness in both knees and patellofemoral crepitus on the left, less so on the right. Dr. Flood stated that x-rays of the knees were unremarkable for the right knee except for some changes in the patella with spurring. X-rays of the left knee showed some spurring on the posteromedial aspect of the notch and more severe patellofemoral changes than were seen in the right knee. Dr. Flood reviewed magnetic resonance imaging (MRI) scans of the knees taken on September 15, 1999. He found bilateral small effusions with fluid in the lateral gutter of both knees. Dr. Flood also found patellofemoral changes, more severe on the left than the right. He noted evidence of lateral retinacular release in the left knee and bilateral small posteromedial and posterolateral partial meniscectomies. Dr. Flood stated that appellant had some degenerative changes in the menisci on the left but saw no evidence of a lateral meniscal tear. He concluded that appellant, as a result of his employment injuries and multiple knee arthroscopies, had degenerative changes in both knees. However, Dr. Flood did not find evidence of meniscal pathology. He stated that appellant had fairly severe restrictions for work. Dr. Flood indicated that appellant could squat with full range of motion of the knees but with obvious discomfort. He concluded that appellant would be limited to a sedentary-type job where he would need freedom of motion, the ability to get up, move about, sit and rest intermittently as needed. Dr. Flood restricted appellant from all climbing on ladders and indicated that he should climb no more than four flights of stairs in one eight-hour work shift. He stated that appellant should not be required to do any repetitive bending, stooping, squatting or duck walking.

Appellant submitted several radiological reports in support of his claim that he could not perform the duties of a chauffeur. In an August 29, 2000 report, Dr. Scott D. Mills, a Board-certified radiologist, reported that an MRI scan of the right knee showed a small chondral cartilage defect involving the medial femoral condyle, but no evidence of ligamentous or meniscal tear. In a November 2, 2000 report, Dr. Charles A. Lim, a Board-certified radiologist, stated that a cervical MRI scan showed mild degenerative joint and disc disease most evidence from C3-4 to C5-6. He noted disc desiccation with some minimal disc bulge and posterior bony spurring. Dr. Lim indicated that no herniation or stenosis was present. On December 6, 2000 appellant underwent additional surgery on his right knee for removal of loose bodies and medial femoral condyle thermal and abrasion chondroplasty. In a February 2, 2001 report, Dr. Bruce Knox, a Board-certified radiologist, indicated that a lumbar MRI scan showed disc desiccation and discogenic changes from T12-L1 through L3-4, mild disc bulging at the L1-2 and L2-3 levels with ligamentous and facet hypertrophy and mild neural canal narrowing on the left at the L4-5 and L5-S1 levels.

Dr. Christopher Lew, a Board-certified anesthesiologist, diagnosed lumbar radiculopathy, chronic knee joint problems, cervical strain and depression and anxiety in several medical reports. In an October 5, 2000 note, Dr. Lew indicated that appellant was taking Oxcycontin, Xanax and Celebrex, which were not entirely effective. In subsequent reports, he indicated that appellant was experiencing chronic, constant pain. In a December 1, 2000 report, Dr. Lew stated that appellant had multiple pain problems including cervical degenerative disc disease, chronic lumbar radiculopathy and chronic mechanical knee pain. He also noted that appellant had depression and anxiety. Dr. Lew indicated that appellant's knee pain and back pain were related to employment injuries over the years. He related appellant's depression and anxiety to the

chronic pain and disability. Dr. Lew discussed proposed surgery on appellant's knee, stating that it should only be expected to improve the function of the knee and not the condition of the other knee or the back. He described the other treatment available to appellant. Dr. Lew stated that, because of the bilateral joint disease, excessive stooping, crouching, crawling and climbing should be avoided. He indicated that, because of appellant's back condition, bending, lifting and repetitive motions of the spine should be avoided. Dr. Lew stated that occupational driving was not permitted due to appellant's back and leg conditions.

The duties of a chauffeur include assisting passengers to enter and exit a car, keeping the car clean, polished and in operating condition, and performing minor repairs as necessary such as fixing flat tires, cleaning spark plugs or adjusting the carburetor. It requires the ability to lift up to 20 pounds and do occasional stooping and crouching. As Dr. Lew stated that appellant should avoid lifting and excessive crouching and stooping, his report shows that appellant could not perform the duties of a chauffeur. Dr. Ebead, in his report, indicated that appellant could lift up to 25 pounds, could sit up to 8 hours a day and could perform light duties. He concluded that appellant could perform the duties of a chauffeur. There exists, therefor, a conflict in the medical evidence between Drs. Ebead and Lew on whether appellant could perform the duties of a chauffeur. Because there is a conflict in the medical evidence, the Office has not met its burden of proof in establishing that appellant could perform the duties of a chauffeur.

The decisions of the Office of Workers' Compensation Programs dated August 31 and January 3, 2001 are hereby reversed.

Dated, Washington, DC
February 6, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member