United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 08-1658**
	)	**Issued: January 9, 2009**
DEPARTMENT OF AGRICULTURE, FSIS, Chattanooga, TN, Employer	)	

Appearances:
Appellant, pro se
No appearance, for the Director

Oral Argument October 22, 2008

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 23, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' March 5, 2008 wage-earning capacity decision. He also appealed a May 1, 2008 decision which denied modification of the wage-earning capacity decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether the Office met its burden of proof in reducing appellant's compensation based on its determination that the constructed position of cashier II represented appellant's wage-earning capacity; and (2) whether the Office properly denied modification of appellant's loss of wage-earning capacity determination.

FACTUAL HISTORY

On July 27, 1983 appellant, then a 31-year-old food inspector, fell at work and injured his low back. The Office accepted his claim for lumbar strain, intervertebral disc disorder with

myelopathy, internal derangement of the left lateral meniscus and expanded his claim to include chronic pain syndrome. Appellant stopped work on July 27, 1983 and received appropriate compensation benefits for all periods of disability.[1]

Appellant came under the treatment of Dr. C. Chandra, a Board-certified orthopedic surgeon. On January 24, 1984 he underwent a lumbar myelogram which revealed extradural defect at L4-5 consistent with central herniated disc. On February 18, 1985 Dr. Chandra performed a posterior lateral fusion at L4 to S1 with foraminotomy bilaterally at L4-5 and L5-S1 and with discectomy at L4-5. He diagnosed bilateral facet hypertrophy at L4-5, L5-S1 with encroachment on the neuroforamina bilaterally at L4-5 and L5-S1 upon spinal cord and nerve root. Subsequently, Dr. Chandra noted that appellant developed bilateral knee pain, worse on the left. On November 11, 1985 he performed left arthroscopic partial synovectomy with debridement and resection of medial suprapatellar plica and diagnosed internal derangement of the left knee with reactive synovitis, small suprapatellar plica and a small radial tear on the left lateral meniscus. On January 9, 1998 Dr. Chandra performed an arthroscopy and chondroplasty and extensive debridement of the left knee joint and diagnosed degenerative arthritis with gout and pseudogout in the left knee. Thereafter, he treated appellant for traumatic osteoarthritis with overlying gouty arthritis of the knees and degenerative disc disease.

Appellant was also treated by Dr. Paul A. Broadstone, an orthopedic surgeon. On February 6, 1990 Dr. Broadstone performed a repair of pseudoarthrosis with L4-5 posterior instrumentation and posterior spinal fusion and diagnosed pseudoarthrosis at L4-5. Later reports from him noted appellant's fusion at L4-5 failed and he recommended a repair of the pseudoarthrosis. On March 23, 1995 Dr. Broadstone performed an anterior retroperitoneal approach to L4-5 and L4-5 anterior discectomy with interbody fusion and diagnosed pseudoarthrosis of L4-5. He continued to treat appellant for low back pain, diagnosing facet arthropathy, postoperative lumbar spine, status post fusion and status post internal fixation at L4-5.

On April 20, 2006 Dr. Chandra opined that appellant could perform a sedentary job with limited standing and sitting.

On March 15, 2007 Dr. Broadstone recommended a functional capacity evaluation. On March 30, 2007 appellant underwent a functional capacity evaluation which revealed that he was classified in the medium strength level, with restrictions of lifting up to 30 pounds occasionally and 15 pounds frequently and carrying up to 30 pounds occasionally and 15 pounds frequently, frequent walking, occasional stooping/repeated bending, kneeling to the right only and no crouching. In a June 15, 2007 report, Dr. Broadstone noted treating appellant for axial lumbar pain, right lower extremity weakness and pain. He provided work restrictions based on the functional capacity evaluation and noted appellant could work full time at modified duty as tolerated.

On June 27, 2007 appellant was referred for vocational rehabilitation. In a September 17, 2007 rehabilitation plan, the rehabilitation counselor recommended a 90-day job placement plan

[1] On December 8, 1993 the Office issued appellant a schedule award for 15 percent impairment of the left leg.

and noted that appellant could perform medium physical demand category with restrictions of lifting floor to knuckle and carrying of 30 pounds occasionally and 15 pounds frequently, with positional restrictions of frequent walking, occasional stooping/repeated bending, kneeling to the right knee only and no crouching. A rehabilitation plan was prepared and approved by the rehabilitation counselor and appellant with the objective of obtaining a position of cashier II, sales attendant, parking attendant and gate guard with average weekly wages of $302.00 for a cashier II, $328.40 for a hotel clerk, $358.40 for a security guard. The counselor stated that these jobs were within appellant's educational capabilities based on vocational testing services. The rehabilitation counselor noted that these positions were reasonably available in appellant's commuting area and attached job classification for the positions.

Appellant submitted an August 7, 2007 report from Dr. Chandra, who noted appellant was doing well and diagnosed bilateral osteoarthritis secondary to trauma and left worse than right, patellofemoral problems.

On October 17, 2007 the Office advised appellant that the rehabilitation plan was within his work restrictions. The Office advised that the rehabilitation counselor's vocational evaluation and survey of the local labor market revealed a wage-earning capacity of $12,480.00 per year. The Office further advised appellant that at the end of the rehabilitation program, whether employed or not, the Office would reduce his compensation.

Appellant submitted October 10 and November 1, 2007 reports from Dr. Broadstone, who prescribed medication for lower extremity pain and for depression due to his work injury. On December 19, 2007 Dr. Broadstone diagnosed facet arthropathy at L3-4 and status post fusion and internal fixation at L4-5. He recommended appellant continue with restrictions previously given and continue his home exercise program.

In vocational rehabilitation reports dated October 30 to December 31, 2007, the counselor noted appellant had a felony conviction for conspiracy to commit arson and could not carry a gun which might prohibit him from obtaining a security guard job.

Appellant submitted reports dated October 15 and December 20, 2007 from Dr. Chandra for treatment of generalized soreness with tenderness around the knee cap. Dr. Chandra diagnosed bilateral calcific menisci and mild arthritic changes.

In a vocational rehabilitation report dated January 15, 2008, the counselor noted that appellant's opportunities for employment were greatly reduced due to his age, lack of transferable skills, length of unemployment and disabling conditions. He noted that had appellant been motivated to return to work he would have been able to secure one of the positions he was referred for during the job search. In an e-mail dated January 24, 2008, the vocational rehabilitation counselor advised that appellant did not wish to continue the job search. He noted that appellant's efforts in the job search were not satisfactory as he did not follow up on all job leads developed for him and was not motivated to find work.

In a January 29, 2008 closure memorandum, the rehabilitation counselor advised that an updated labor market survey revealed the market was favorable for a cashier II, and that the

positions were readily available in sufficient numbers both full and part time in appellant's commuting area. The average weekly wage of a cashier II, DOT No. 211.462.010 was $302.00. The rehabilitation counselor noted that appellant was not interested in any training services which might have provided skill enhancement. He reported identifying employers with suitable jobs for appellant but appellant did not obtain employment. The rehabilitation counselor noted that there were 415 annual job vacancies for cashiers with an entry level of $6.20 per hour, based on a state labor market survey, which matched appellant's qualifications and medical restrictions. The counselor further noted that the position was consistent with the medical restrictions provided by Dr. Broadstone and the functional capacity evaluation of March 30, 2007.

On January 31, 2008 the Office issued a proposed reduction of compensation finding that the evidence established that appellant was partially disabled and had the capacity to earn wages as a cashier II, at the rate of $248.00 per week. The Office noted that this position was in compliance with Dr. Broadstone's restrictions and the functional capacity evaluation. The Office referenced the rehabilitation counselor's report which determined that appellant would be employable as a cashier II which reasonably represents his wage-earning capacity.

Appellant submitted a functional capacity report dated February 8, 2008 from a vocational evaluator. He stated that it took him seven days to recover from the functional assessment. The evaluator recommended short-term vocational training which would enable appellant to work from home in a sedentary job. In a statement dated February 15, 2008, appellant asserted that the Office failed to consider that he had a broken screw in his back and had developed arthritis. He contended that he was unable to perform a job search but gave it his honest effort and only had two interviews in 90 days. In a report dated February 7, 2008, Dr. Chandra noted tenderness around the medial and lateral radius of the left knee with a mild effusion. He injected appellant's left knee with Marcaine and recommended arthroscopic debridement.

In a March 5, 2008 decision, the Office adjusted appellant's compensation to reflect his wage-earning capacity as a cashier II effective March 16, 2008.

Appellant requested reconsideration on March 11, 2008. In a February 20, 2008 report, Dr. William A. Wray, a clinical psychologist, diagnosed chronic pain disorder, seizure disorder and depressive disorder. He concluded that due to pain, physical limitations, adverse medication effects, sleep disruption problems and clinical depression appellant was not capable of successfully engaging in sustained employment activity of any type. A March 18, 2008 report from Dr. Broadstone noted appellant was unable to sit or stand for more than three hours at a time due to his condition.

In a decision dated May 1, 2008, the Office denied modification of the March 5, 2008 decision.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[2]

Under section 8115(a) of the Federal Employees' Compensation Act,[3] titled "Determination of Wage-Earning Capacity" states in pertinent part: "In determining compensation for partial disability, the wage-earning capacity of an employee is determined by his actual earnings if his actual earnings fairly and reasonably represent his wage-earning capacity." Generally, wages actually earned are the best measure of a wage-earning capacity and in the absence of evidence showing they do not fairly and reasonably represent the injured employee's wage-earning capacity, must be accepted as such measure.[4] If the actual earnings do not fairly and reasonably represent wage-earning capacity, or if the employee has no actual earnings, his wage-earning capacity is determined with due regard to the nature of his injury, his degree of physical impairment, his usual employment, his age, his qualifications for other employment, the availability of suitable employment and other factors and circumstances which may affect his wage-earning capacity in his disabled condition.[5] Wage-earning capacity is a measure of the employee's ability to earn wages in the open labor market under normal employment conditions.[6] The job selected for determining wage-earning capacity must be a job reasonably available in the general labor market in the commuting area in which the employee lives.[7] 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.[8]

When the Office makes a medical determination of partial disability and of specific work restrictions, it may refer the employee's case to a vocational rehabilitation counselor authorized by the Office or to an Office wage-earning capacity specialist for selection of a position, listed in the Department of Labor's *Dictionary of Occupational Titles* or otherwise available in the open labor market, that fits that employee's capabilities with regard to his physical limitation, education, age and prior experience. Once this selection is made, a determination of wage rate and availability in the open labor market should be made through contact with the state employment service or other applicable service.[9] Finally, application of the principles set forth

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[2] *Bettye F. Wade*, 37 ECAB 556, 565 (1986); *Ella M. Gardner*, 36 ECAB 238, 241 (1984).

[3] 5 U.S.C. § 8115.

[4] *Hubert F. Myatt*, 32 ECAB 1994 (1981); *Lee R. Sires*, 23 ECAB 12 (1971).

[5] *See Pope D. Cox*, 39 ECAB 143, 148 (1988); 5 U.S.C. § 8115(a).

[6] *Albert L. Poe*, 37 ECAB 684, 690 (1986); *David Smith*, 34 ECAB 409, 411 (1982).

[7] *Id*.

[8] *Steven M. Gourley*, 39 ECAB 413 (1988); *William H. Goff*, 35 ECAB 581 (1984).

[9] *Karen L. Lonon-Jones*, 50 ECAB 293, 297 (1999).

in *Albert C. Shadrick* will result in the percentage of the employee's loss of wage-earning capacity.[10]

ANALYSIS -- ISSUE 1

Appellant received compensation for total disability after his accepted conditions precluded his return to work with the employing establishment. However, Dr. Broadstone, appellant's treating physician reviewed a functional capacity evaluation and advised that appellant was not disabled for all work. Appellant was found capable of work in the medium strength level, with restrictions of lifting up to 30 pounds occasionally and 15 pounds frequently and carrying up to 30 pounds occasionally and 15 pounds frequently, frequent walking, occasional stooping/repeated bending, kneeling to the right only and no crouching.

The Office referred appellant for vocational rehabilitation counseling. The vocational counselor advised that appellant's opportunities for employment were greatly reduced due to his age, lack of transferable skills, length of unemployment, lack of motivation, failure to follow up on leads and disabling conditions. After appellant was unable to secure employment, on January 29, 2008 the vocational counselor identified the position of a cashier II, as work that appellant would be capable of performing and which was available in his area.[11] The vocational counselor identified the position in the Department of Labor's *Dictionary of Occupational Titles*, DOT No. 211.462.010, and provided the required information concerning the position description, the availability of the position within appellant's commuting area and pay ranges within the geographical area, as confirmed by state officials. He determined that the cashier II position was in accord with appellant's background, education, and experience. The rehabilitation counselor noted that the labor market survey revealed the market was favorable as the cashier II was readily available in sufficient numbers both full and part time in appellant's commuting area. The average weekly wage of a cashier II was $248.00 per week with hiring occurring regularly. The counselor further noted that the position was consistent with appellant's medical restrictions as set forth by Dr. Broadstone on June 15, 2007.

The Board finds that the Office met its burden of proof in reducing appellant's compensation based on his ability to earn wages as a cashier II. The medical evidence establishes that appellant is capable of performing the duties required in the selected position of cashier II. On June 15, 2007 Dr. Broadstone provided work restrictions based on the functional capacity evaluation and noted that appellant could return to work full time, modified duty as tolerated. The duties of the selected position conform with the recommended limitations. In a subsequent report dated December 19, 2007, Dr. Broadstone recommended appellant continue with the same physical restrictions. Other reports from Dr. Chandra, dated August 7 to February 7, 2008, noted appellant was doing well and diagnosed bilateral osteoarthritis

[10] *Id. See Shadrick* at 5 ECAB 376 (1953).

[11] Where vocational rehabilitation is unsuccessful, the rehabilitation counselor will prepare a final report, which lists two or three jobs which are medically and vocationally suitable for the employee and proceed with information from a labor market survey to determine the availability and wage rate of the position. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reemployment: Determining Wage-Earning Capacity*, Chapter 2.814.8(b) (December 1995); *see also Dorothy Jett*, 52 ECAB 246 (2001).

secondary to trauma and left worse than right and patellofemoral problems. However, these reports do not establish that appellant was disabled of performing the duties required as a cashier II.

The Board finds that the Office also considered the proper factors, such as availability of suitable employment and appellant's physical limitations, usual employment, and age and employment qualifications, in determining that the position of cashier II represented appellant's wage-earning capacity. The weight of the evidence of record establishes that appellant had the requisite physical ability, skill and experience to perform the position of cashier II and that such a position was reasonably available within the general labor market of appellant's commuting area. The Office properly determined that the position of cashier II reflected appellant's wage-earning capacity and reduced appellant's compensation effective March 16, 2008.

Appellant asserted that the Office failed to consider that he had a broken screw in his back and had developed two types of arthritis. He further contended that he was unable to perform a job search and that the stress and pain were more than he could bear. However, appellant submitted no medical evidence to establish he was not qualified to perform the duties of a cashier II. As noted, the medical evidence supports that he is physically capable of performing the position as a cashier II and the rehabilitation counselor found that the position was in accord with appellant's background, education and experience. Appellant submitted a functional capacity evaluation, dated February 8, 2008, in which the evaluator opined that based on his situational assessment and subsequent pain it was questionable whether he could work a public job. However, the question of whether appellant is medically able to work is a medical question and the functional capacity evaluation is not from a physician.[12] The evaluation also fails to specifically address the position of cashier II.

The Board finds that the Office properly determined that the position of cashier II reflected appellant's wage-earning capacity effective March 16, 2008.

LEGAL PRECEDENT -- ISSUE 2

Once the loss of wage-earning capacity is determined, a modification of such determination is not warranted unless there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated, or the original determination was, in fact, erroneous.[13] The burden of proof is on the party attempting to show modification of the award.[14]

[12] *See* 5 U.S.C. § 8101(2). This subsection defines the term "physician." *See also Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (where the Board held that medical opinion, in general, can only be given by a qualified physician).

[13] *George W. Coleman*, 38 ECAB 782, 788 (1987); *Ernest Donelson, Sr.*, 35 ECAB 503, 505 (1984).

[14] *James D. Champlain*, 44 ECAB 438 (1993); *Jack E. Rohrabaugh*, 38 ECAB 186, 190 (1986).

ANALYSIS -- ISSUE 2

After the Office properly found that appellant could perform the duties of a cashier II, the pertinent medical issue is whether there had been any change in his condition that would render him unable to perform those duties.[15] For a physician's opinion to be relevant on this issue, the physician must address the duties of the constructed position.[16] However, medical evidence submitted by appellant after the loss of wage-earning capacity determination did not sufficiently explain why the duties of the position of cashier II were unsuitable.

On February 20, 2008 Dr. William A. Wray diagnosed chronic pain disorder, seizure disorder and depressive disorder and opined that, due to pain, physical limitations, adverse medication effects, sleep disruption problems and clinical depression, appellant was not capable of successfully engaging in sustained employment activity of any type. However, the Office did not accept that appellant developed depression as a result of his work injury and Dr. Wray did not otherwise explain how it was due to the accepted back or knee conditions. The Board has found that vague and nationalized medical opinions on causal relationship have little probative value.[17]

On March 18, 2008 Dr. Broadstone noted that appellant was unable to sit or stand for more than three hours at a time due to his condition. However, he did not provide sufficient medical rationale explaining how any of appellant's injury-related conditions would disable appellant from a position of a cashier.[18] Dr. Broadstone did not specifically address the duties of the cashier II position or note any change in appellant's injury-related condition that would render him unable to perform the position of cashier. Therefore, these reports did not establish that appellant could not perform the duties of a cashier II.

The Board finds that there is no medical evidence which establishes a change in appellant's employment-related condition such that a modification of the Office's wage-earning capacity determination would be warranted. The evidence from Dr. Wray and Dr. Broadstone does not establish that the position of cashier II was improper. Appellant also did not otherwise establish a basis for modification by submitting evidence establishing that he had been retrained or otherwise vocationally rehabilitated, or that the original determination was, in fact, erroneous. Consequently, he has failed to carry his burden of proof to establish modification of the wage-earning capacity determination.

[15] *Phillip S. Deering*, 47 ECAB 692 (1996).

[16] *Id.*

[17] *See Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

[18] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

CONCLUSION

The Board finds that the Office properly determined that the position of cashier II reflects appellant's wage-earning capacity effective March 16, 2008. The Board further finds that appellant did not submit sufficient evidence, following the Office's October 16, 2006 decision, to modify the Office's loss of wage-earning capacity determination.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated May 1 and March 5, 2008 are affirmed.

Issued: January 9, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board