

**United States Department of Labor  
Employees' Compensation Appeals Board**

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G.C., Appellant

and

U.S. POSTAL SERVICE, FORT DEARBORN  
STATION, Chicago, IL, Employer

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**Docket No. 16-1503  
Issued: May 17, 2017**

*Appearances:*  
*Jeffrey P. Zeelander, Esq.*, for the appellant<sup>1</sup>  
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:  
PATRICIA H. FITZGERALD, Deputy Chief Judge  
COLLEEN DUFFY KIKO, Judge  
ALEC J. KOROMILAS, Alternate Judge

**JURISDICTION**

On July 15, 2016 appellant, through counsel, filed a timely appeal from a June 3, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

**ISSUE**

The issue is whether appellant met his burden of proof to establish intermittent disability beginning in July 2015, and total disability beginning September 1, 2015.

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<sup>1</sup> In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; see also 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

On appeal counsel notes that appellant initially filed an occupational disease claim (Form CA-2), not a traumatic injury claim (Form CA-1). He asserts on appeal that the medical evidence of record is sufficient to establish that appellant's work duties permanently aggravated the arthritis in his knees and that the claimed recurrence should be accepted.

### **FACTUAL HISTORY**

On December 12, 2011 appellant, then a 52-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that his work duties caused knee arthritis and meniscal tears. He did not stop work at that time. In an attached statement, appellant related that his knees had been hurting for about 10 years, and that he began medical treatment for knee pain the past October.<sup>3</sup>

In a March 13, 2012 report, Dr. Jay M. Brooker, a Board-certified orthopedic surgeon, noted appellant's 20-year history of postal work with progressively worsening knee pain, made worse by work duties. He reported magnetic resonance imaging (MRI) scan findings of degenerative tears in appellant's knees. Dr. Brooker opined that MRI scan findings were the result of appellant's job duties of repetitive climbing, crouching, kneeling, and lifting.

On April 10, 2012 OWCP accepted temporary aggravation of preexisting degenerative tears of the knee, bilateral. Appellant stopped work on May 1, 2012, pending surgery. Dr. Brooker performed authorized right knee arthroscopic surgery on May 15, 2012. Appellant received wage-loss compensation and medical benefits and was placed on the periodic compensation rolls. On June 13, 2012 Dr. Brooker reported that appellant's right knee was improving after surgery and that he now needed left knee surgery, which was scheduled for July 2012. He attached a November 1, 2011 left knee MRI scan report which reflected a medial meniscal tear with moderate patellofemoral compartment and mild medial compartment degenerative changes. On July 17, 2012 Dr. Brooker performed authorized left knee arthroscopy. He provided follow-up treatment, noting on August 21, 2012 that appellant had regained good stability and strength, with remaining soreness and grinding due to bilateral patellofemoral chondromalacia.

Appellant returned to full-time modified duty on September 24, 2012. He continued to have problems with his knees. On December 3, 2012 and January 23, 2013 Dr. Brooker noted appellant's complaint of persistent achiness and soreness of both knees. He reported x-ray findings of minor medial joint space narrowing and tenderness on examination. Dr. Brooker diagnosed degenerative arthritis.

Appellant filed claims for compensation CA-7 forms for intermittent periods of disability beginning January 23, 2013. On April 8, 2013 Dr. Brooker reported that appellant's bilateral knee arthritis was worsening.

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<sup>3</sup> See *infra* note 4, describing medical evidence submitted after the claim was accepted.

On April 16, 2013 OWCP accepted the January 23, 2013 recurrence of disability and appellant was returned to the periodic compensation rolls.<sup>4</sup>

Dr. Brooker performed right knee partial medial meniscectomy on June 10, 2014. On September 15, 2014 he advised that appellant could return to work on September 22, 2014 with a permanent driving route, no lifting over 40 pounds, and no climbing, crouching, or kneeling. Walking was restricted to 20 minutes over level ground with 20-minute breaks at intervals during the day.

On September 16, 2014 appellant accepted a modified assignment that included driving a vehicle eight hours a day with two hours delivering express mail, four hours delivering parcel post, and two hours of relays. Lifting was restricted to 40 pounds, with walking at intervals. Appellant returned to work on September 22, 2014. On work capacity evaluations dated January 30 and July 1, 2015, Dr. Brooker indicated that appellant could not perform his usual job and that he was at maximum medical improvement. He advised that appellant could work eight hours daily with permanent restrictions of walking and standing on level ground only, no squatting, kneeling, or climbing, and lifting restricted to 20 pounds.<sup>5</sup>

Appellant began working reduced hours on July 6, 2015. He indicated that his restrictions had increased and he could no longer work eight hours. On September 2, 2015 appellant filed a recurrence claim (Form CA-2a). He indicated that he could stand for only 20 minutes at a time due to knee pain when he returned to work in September 2014, but could now stand only 5 to 10 minutes at a time. Appellant related that his condition did not improve, that his left knee was now bone-on-bone, and that he could work only four hours a day. He also filed a Form CA-7, claim for compensation for intermittent periods from July 13 to September 5, 2015. An attached time analysis form (Form CA-7a) indicated that from July 13 to September 15, 2015 appellant worked part time and claimed partial disability compensation for the remainder, advising "too much pain in my knees." Authorization for left total knee arthroplasty was requested.

On October 7, 2015 Dr. Brooker advised that a left total arthroscopy was scheduled and that it was unclear when appellant could return to work.

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<sup>4</sup> At this time appellant also submitted treatment notes from Dr. Brooker dated October 11, 2011 to April 8, 2013. Dr. Brooker reported on October 11, 2011 that appellant was seen for evaluation of bilateral knee pain. Appellant had full range of motion bilaterally on examination. Dr. Brooker diagnosed bilateral knee pain, rule out degenerative tear of the meniscus. On November 29, 2011 he reported that MRI scans of each knee demonstrated undisplaced posterior medial meniscal tears with degeneration of the patellofemoral joint. On January 9, 2012 Dr. Brooker noted appellant's continued complaint of bilateral knee pain. He diagnosed bilateral minimal degenerative findings with degenerative meniscal tears and recommended a trial injection. On January 30, 2012 Dr. Brooker advised that appellant's right knee remained painful after injection, with examination findings of a positive McMurray test and mild effusion. He recommended arthroscopy. On May 22, 2012 Dr. Brooker noted that appellant was seen in follow up after right knee arthroscopy and was doing well. He described follow-up care for the left knee arthroscopy in notes dated July 24 and September 21, 2012.

<sup>5</sup> The record also contains treatment notes from Dr. Brooker's office dated October 20, 2014 to October 7, 2015, which were electronically signed by transcriptionists J.S., C.H., D.G., or P.P. In addition, there is an unsigned letter dated October 7, 2015. None is signed by a physician.

On October 8, 2015 OWCP asked its medical adviser to comment on whether a requested left total knee arthroplasty should be authorized. It noted that a temporary aggravation of preexisting degenerative tears of meniscus of knee, bilateral, had been accepted.

In correspondence dated October 8, 2015, OWCP informed appellant of the evidence needed to support his recurrence claim and the request for knee surgery.

Appellant completed an OWCP development questionnaire on October 22, 2015. He related that he had daily frequent, intense knee pain that continued to worsen. Appellant described job duties, noting that until July he screened parcels from 4:00 to 7:00 a.m. when he began delivering express mail and that, beginning in July, he began work at 7:00 a.m. and did express mail only. He reported that presently he could not even do that and had several knee injections that did not work.

In an October 30, 2015 report, Dr. Michael Hellman, an orthopedic surgeon and OWCP medical adviser, reviewed the record. He noted that appellant had a work-related injury on October 17, 2011 that caused a temporary aggravation of bilateral knee arthritis, noting that a November 1, 2011 MRI scan clearly showed preexisting arthritis. The medical adviser opined that the underlying arthritis should not be considered work related and should not be authorized by OWCP. He recommended that appellant use private insurance to cover the requested total knee replacement.

Appellant submitted Form CA-7 claims for compensation for disability during the periods October 5 to 24 and November 9 to 21, 2015.

In a December 9, 2015 report, Dr. Brooker advised that appellant's knee arthritis was caused by years of repetitive climbing, crouching, kneeling, lifting, twisting, and turning that led to the tearing in his knees. This subsequently led to more arthritis after removal of the cartilage, leading to bone-on-bone degenerative arthritis. Dr. Brooker explained that knee cartilage started to deteriorate with repetitive usage, noting that because appellant's pain was so severe, he required arthroscopic debridement. He continued that the condition would worsen through time and the arthritis would become so severe that the only treatment available was knee replacement. Dr. Brooker advised that appellant had degenerative meniscal pathology in both knees that had deteriorated over time as a result of the 25 years of heavy lifting, climbing, crouching, kneeling, stair climbing, and repetitive walking on daily routes as a letter carrier. He opined that the exacerbation of meniscal tears seen in appellant was a natural course and that, within several years of undergoing arthroscopic debridement, a patient would become bone-on-bone and could require further surgery. Dr. Brooker maintained that appellant's bilateral knee condition would not have occurred had his condition not been exacerbated by work duties. He noted that there had been no improvement of appellant's condition, and at the present time appellant could only perform seated work with no lifting, climbing, crouching or kneeling, and no walking or standing for prolonged periods of time. Dr. Brooker concluded that appellant was in tremendous pain, which would not be alleviated without a knee replacement.

By decision dated December 17, 2015, OWCP denied appellant's recurrence claim, finding that the medical evidence submitted was insufficient to establish that the claimed recurrence was due to the accepted condition.<sup>6</sup>

On January 15, 2016 appellant requested reconsideration. He explained that he had been a letter carrier for 26 years and had only worked modified duty in the last four years. Appellant resubmitted Dr. Brooker's December 9, 2015 report.<sup>7</sup>

In a merit decision dated June 3, 2016, OWCP denied modification of its December 17, 2015 decision. It found that, based on the November 1, 2011 MRI scan that clearly showed preexisting arthritis, the medical evidence, including Dr. Brooker's December 9, 2015 report, was of limited probative value on the issue of causal relationship.

### **LEGAL PRECEDENT**

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.<sup>8</sup> This term also means an inability to work when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.<sup>9</sup>

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that light duty can be performed, the employee has the burden to establish by the weight of reliable, probative, and substantial evidence a recurrence of total disability. As part of this burden of proof, the employee must show either a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light-duty requirements.<sup>10</sup>

An individual who claims a recurrence of disability resulting from an accepted employment injury has the burden of establishing that the disability is related to the accepted injury. This burden requires furnishing medical evidence from a physician who, on the basis of a

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<sup>6</sup> The decision was initially issued on November 23, 2015 and was reissued on December 17, 2015 because appeal rights were not forwarded with the November 23, 2015 decision.

<sup>7</sup> Appellant had initially requested a hearing with OWCP's Branch of Hearings and Review, but subsequently withdrew the request. The record also contains treatment notes from Dr. Brooker's office dated January 6 and March 2, 2016, which were electronically signed by transcriptionists C.H., and P.P. *Supra* note 6.

<sup>8</sup> 20 C.F.R. § 10.5(x); see *Theresa L. Andrews*, 55 ECAB 719 (2004).

<sup>9</sup> *Id.*

<sup>10</sup> *Shelly A. Paolinetti*, 52 ECAB 391 (2001); *Robert Kirby*, 51 ECAB 474 (2000); *Terry R. Hedman*, 38 ECAB 222 (1986).

complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.<sup>11</sup>

### ANALYSIS

The Board finds that appellant failed to meet his burden of proof to establish a recurrence of disability beginning in July 2015 causally related to the accepted temporary aggravation of preexisting degenerative tears of bilateral knee menisci. Appellant failed to establish that the nature and extent of these injury-related conditions changed so as to prevent him from continuing to perform his modified assignment.

A partially disabled claimant who returns to a light-duty job has the burden of proving that he or she cannot perform the light duty, if a recurrence of total disability is claimed.<sup>12</sup> The issue of whether an employee has disability from performing a modified position is primarily a medical question and must be resolved by probative medical evidence.<sup>13</sup> A claimant's burden includes the necessity of furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound medical rationale. Where no such rationale is present, the medical evidence is of diminished probative value.<sup>14</sup>

Following acceptance of bilateral knee conditions and right knee total arthroplasty on May 15, 2012, appellant returned to modified duty. At the time of the claimed recurrence in July 2015, he was performing duties that included driving a vehicle eight hours a day with two hours delivering express mail, four hours delivering parcel post, and two hours of relays. Lifting was restricted to 40 pounds, with walking at intervals.

In October 2015, Dr. Brooker requested authorization for left total knee arthroscopy and advised that it was unclear when appellant could return to work. Dr. Hellman, an OWCP medical adviser, indicated that appellant's underlying knee arthritis should not be considered work related and recommended that the proposed left knee replacement surgery not be authorized.

In a December 9, 2015 report, Dr. Brooker advised that appellant's knee arthritis was caused by years of repetitive climbing, crouching, kneeling, lifting, twisting, and turning that led to the tearing in his knees which subsequently led to more arthritis after removal of the cartilage, leading to bone-on-bone degenerative arthritis. However, the accepted condition is temporary aggravation of degenerative meniscal tears and not the underlying arthritis. Dr. Brooker maintained that appellant could only perform seated work due to tremendous pain which could only be alleviated by left knee replacement surgery. He did not attribute the claimed disability to

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<sup>11</sup> *S.S.*, 59 ECAB 315 (2008).

<sup>12</sup> *See William M. Bailey*, 51 ECAB 197 (1999).

<sup>13</sup> *Cecelia M. Corley*, 56 ECAB 662 (2005).

<sup>14</sup> *Mary A. Ceglia*, 55 ECAB 626 (2004).

the accepted temporary aggravation of preexisting degenerative tears of bilateral knee menisci. As noted, when an employee returns to light-duty work, he or she has the burden to establish a recurrence of disability due to the employment-related conditions, and that he or she cannot perform such light duty.<sup>15</sup> The employee must show a change in the nature of the accepted condition or a change in the light-duty job requirements.<sup>16</sup> Appellant submitted no such evidence in this case.

OWCP also received unsigned treatment notes and a letter. A medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a “physician” as defined in 5 U.S.C. § 8102(2). Reports lacking proper identification, such as unsigned treatment notes, do not constitute probative medical evidence.<sup>17</sup>

On appeal counsel asserts that the medical evidence establishes that appellant’s work duties permanently aggravated the arthritis in his knees such that the accepted conditions should be revised to include permanent aggravation, and that the claimed recurrence be accepted. However, this matter is not presently before the Board as OWCP’s June 3, 2016 decision did not address whether additional conditions should be accepted.<sup>18</sup>

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

### **CONCLUSION**

The Board finds that appellant failed to meet his burden of proof to establish intermittent disability beginning in July 2015 and total disability beginning September 1, 2015.

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<sup>15</sup> *Supra* note 13.

<sup>16</sup> *See supra* note 11; *K.C.*, Docket No. 09-1666 (issued August 25, 2010).

<sup>17</sup> *R.M.*, 59 ECAB 690 (2008).

<sup>18</sup> *See* 20 C.F.R. § 501.2(c).

**ORDER**

**IT IS HEREBY ORDERED THAT** the June 3, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 17, 2017  
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge  
Employees' Compensation Appeals Board