United States Department of Labor
Employees' Compensation Appeals Board

P.A., Appellant	)	
and	)	**Docket No. 10-1907**
	)	**Issued: June 17, 2011**
U.S. POSTAL SERVICE, POST OFFICE, EAST STOCKTON STATION, Stockton, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 13, 2010 appellant filed an appeal from a June 17, 2010 decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (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 her burden of proof to establish that an April 29, 2009 wage-earning capacity decision should be modified.

FACTUAL HISTORY

On March 24, 1989 appellant, then a 32-year-old carrier technician, filed an occupational disease claim that was accepted for cervical and left shoulder strains and a herniated disc at C5-6. On July 17, 1990 she underwent an anterior discectomy at C5-6 and C6-7. On April 14,

[1] 5 U.S.C. §§ 8101-8193.

1992 appellant had arthroscopic surgery of the left shoulder and the claim was accepted for left rotator cuff tendinitis. She worked intermittently and received wage-loss compensation. Appellant stopped work and was placed on the periodic compensation rolls in October 1994. During additional neck surgery on April 21, 1995, performed by Dr. Moris Senegor, Board-certified in neurosurgery, an arterial bleed was detected and the procedure was aborted. On April 26, 1995 Dr. Senegor advised that appellant was making an uneventful recovery and surgery would be rescheduled. On May 25, 1995 Dr. Meherji A. Oshtory, a Board-certified neurologist, noted her complaints of hesitant speech and cognitive difficulties. He provided findings on examination and noted that a magnetic resonance imaging (MRI) scan of the brain was completely normal. Dr. Oshtory concluded that there was no evidence clinically or on MRI scan of a stroke or a visual field defect. On June 14, 1995 Dr. Senegor performed reconstructive surgery, discectomy and fusion at C6-7. On July 25, 1997 he performed discectomy and fusion at C4-5.

Appellant came under the care of Dr. Beverly Hurwitz, a Board-certified pediatrician, who practices pain management. In a June 6, 2001 report, Dr. Hurwitz advised that appellant could return to modified duty for four hours a day. On July 13, 2002 appellant returned to a modified position as a video coding system technician for four hours daily at a Sacramento, California, processing and distribution center. She continued in that position through October 2002, when she stopped work.[2] Appellant was returned to the periodic compensation rolls in receipt of total disability.

On February 1, 2006 Dr. Blake G. Welling, a Board-certified neurosurgeon, performed a cervical procedure for severe cervical myelopathy secondary to a C3-4 disc herniation. In a July 8, 2006 report, he diagnosed chronic cervical myelopathy with hyperreflexia and sustained clonus. Dr. Welling advised that appellant had reached maximum medical improvement and was totally disabled. By letter dated November 9, 2006, he stated that she could not hold or grasp anything weighing more than five pounds without dropping it and that she had a significant gait disturbance. Dr. Welling concluded that appellant could not return to work.

In July 2007, OWCP referred appellant to Dr. Michael T. Giovanniello, Board-certified in physiatry and pain medicine. On August 16, 2007 Dr. Giovanniello reviewed the record and her complaint of persistent cervical, arm, left shoulder and low back pain with numbness and tingling of the hands and feet. He provided findings on examination and diagnosed a history of work-related left shoulder and cervical spine disease with shoulder surgery and multiple cervical procedures, failed neck syndrome, a complication involving the carotid artery during a previous surgery with probable mild cognitive deficits, chronic pain syndrome with associated depression, narcotic medication dependency and persistent functional deficits due to the work-related conditions. Dr. Giovanniello advised that appellant could not work as a carrier technician and recommended a functional capacity evaluation (FCE) with neuropsychological testing. An attached work capacity evaluation, he advised that her ability to work would be determined after the FCE and psychological testing. Appellant could sit for four to six hours a day, walk and stand for two hours, with no overhead lifting or reaching above the shoulder and no operating a

[2] OWCP referred appellant to Dr. Jozef A. Ottowicz, a Board-certified neurologist. In a thorough November 15, 2004 report, Dr. Ottowicz advised that she could return to part-time modified duty with permanent restrictions. The employing establishment offered appellant a modified position.

motor vehicle at work with a weight restriction of less than 10 pounds and that she should change her position every 15 to 20 minutes.[3]

A November 19, 2007 FCE noted that, based on appellant's response to questionnaires, she perceived herself as being totally disabled with unreliable reports of pain and symptoms. Testing demonstrated that she was capable of meeting a light physical demand work level, noting that she was able to walk comfortably without observed intolerance, was able to climb stairs without difficulty and could reach forward and overhead to the floor without reported discomfort. Appellant reported limitations in sitting but tolerated standing well and reported increased pain with lifting, carrying, pushing and dexterity tasks.

On May 13, 2008 Dr. Christine W. Burns, a licensed clinical psychologist, performed psychological testing. She advised that appellant's performance on measures of verbal learning, memory, visuospatial ability, attention and language fell within the average to superior range. Appellant had mild-to-moderate levels of depressive and anxiety symptoms, with some anxiety regarding the uncertainty of her future and her work status.

In a supplementary report dated June 10, 2008, Dr. Giovanniello reviewed the FCE and psychological test results. He advised that appellant was capable of modified work, to begin at four hours a day, working up to eight hours at the rate of an additional hour each week. Dr. Giovanniello also recommended that she be followed by a psychologist for her depression and anxiety disorder and a pain specialist to transition her to gainful employment. In an attached work capacity evaluation, he advised that appellant could work eight hours daily with permanent restrictions of four to six hours of sitting daily. Walking and standing were restricted to two hours daily, with no carrying, bending, stooping or operating a motor vehicle at work and limited repetitive movements of the wrists and elbows.[4]

On July 23, 2008 appellant was referred for vocational rehabilitation with Mark Hedrick, a rehabilitation counselor. In reports dated August 7 and 11, 2008, Mr. Hedrick noted that she suffered a mini-stroke on July 11, 2008 and wanted to take time to recover before participating in vocational rehabilitation services. He advised appellant to obtain a letter from her physician explaining why she was unable to participate. On August 21, 2008 OWCP advised her that she should provide a statement from her physician that explained why she could not participate in vocational rehabilitation services and described her medical condition including work restrictions.

In an August 28, 2008 letter, Kevin Henry, a physician's assistant, advised that appellant had a series of strokes, with the initial one on July 13, 2008 and the last on August 8, 2008. He stated that, until her condition stabilized, anticipated to be 12 weeks, she could not participate in

[3] OWCP scheduled an FCE on October 2, 2007 and neuropsychological testing on October 15, 2007. Appellant did not attend either appointment and the FCE was rescheduled for November 19, 2007. The neuropsychological testing was rescheduled for December 10, 2007. Appellant did not attend and the testing was scheduled for March 26, 2008. She left the March 26, 2008 session early and completed the test on May 13, 2008.

[4] Appellant submitted treatment notes dated November 26, 2007 and January 23, 2008 with illegible signatures.

vocational rehabilitation.[5] On August 21, 2008 OWCP informed appellant that the August 28, 2008 report from Mr. Henry was insufficient to establish that she was unable to participate in vocational rehabilitation. Appellant was asked to submit a report from a physician. On September 25, 2008 she agreed to participate in vocational rehabilitation and in an October 25, 2008 report, Mr. Hedrick reported meeting with her on September 30, 2008. At that time appellant informed him that she was physically unable to return to work.

On November 24, 2008 Mr. Hedrick identified the positions of ticket seller and cashier II, parking booth attendant, finding that they were within the light category, within appellant's work restrictions and qualifications and reasonably available in the local labor market.[6] Appellant thereafter traveled to Oklahoma for an indefinite period. In reports dated December 23, 2008, Mr. Hedrick noted his opinion that, while the Department of Labor's *Dictionary of Occupational Titles* (DOT) listed the strength category for both ticket seller and parking booth attendant as "light," it was his opinion that there was also a subset with sedentary exertion requirements and, based on his experience, there was a reasonable number of positions in appellant's commuting area classified as sedentary.

By letter dated March 19, 2009, OWCP proposed to reduce appellant's wage-loss compensation, based on her capacity to earn wages as a cashier II, parking booth attendant.[7] It advised her that, if she disagreed, she should submit additional evidence or argument within 30 days. In an April 10, 2009 letter, appellant's daughter opined that appellant's activity level was severely limited due to her employment injuries. In April 15, 2009 correspondence, appellant asserted that her serious, debilitating pain and physical limitations prevented her from working. She stated that she could sit and stand for only 10 minutes at a time and that she had a series of mini-strokes that limited her cognition. Appellant noted that she took multiple pain medications and asked to be seen by a neurosurgeon. In a March 27, 2009 report, Dr. Kimberly Beck, Board-certified in family medicine, advised that appellant had significant physical limitations and could sit for one to two hours in an eight-hour day but should be allowed breaks to rise, stretch and possibly lay down every 20 minutes for 10 to 15 minutes, with no lifting, pushing or pulling.

[5] Appellant also submitted a number of treatment notes from a pain clinic dated June 5 to August 12, 2008 signed by physician's assistants and nurse practitioners. The reports dated July 17 and August 12, 2008 reported chronic pain complaints but no indication of stroke. Appellant continued to submit pain clinic treatment notes signed by physician's assistants and nurse practitioners, dated September 9 to October 29, 2008.

[6] Mr. Hedrick noted that lifting for both positions was less than 10 pounds and in both positions appellant would have the ability to alternate sitting and standing as needed.

[7] The DOT job description for cashier II, parking booth attendant, was as follows: Receives cash from customers or employees in payment for goods or services and records amounts received: Recomputes or computes bill, itemized lists and tickets showing amount due, using adding machine or cash register. Makes change, cashes checks and issues receipts or tickets to customers. Records amounts received and prepares reports of transactions. Reads and records totals shown on cash register tape and verifies against cash on hand. May be required to know value and features of items for which money is received. May give cash refunds or issue credit memorandums to customers for returned merchandise. May operate ticket-dispensing machine. May operate cash register with peripheral electronic data processing equipment by passing individual price-coded items across electronic scanner to record price, compile printed list and display cost of customer purchase, tax and rebates on monitor screen. May sell candy, cigarettes, gum and gift certificates and issue trading stamps. May be designated according to nature of establishment.

In an April 29, 2009 decision, OWCP reduced appellant's compensation benefits, based on her capacity to earn wages as cashier, parking booth attendant. It found that the weight of the medical evidence was represented by Dr. Giovanniello, who based his opinion regarding her physical capabilities on the November 20, 2007 functional capacity evaluation and on the opinion of Dr. Burns, who advised that appellant's verbal learning, memory, visuospatial ability, attention and language, fell within the average to superior range.

On January 20, 2010 appellant requested reconsideration.[8] She again asserted that she had a stroke on July 11, 2008, stating that she was taken to an emergency room. Appellant maintained that her part-time work in 2002 caused a bulging disc at L2 and described her physical condition. She maintained that she was physically unable to take tickets eight hours a day. A February 23, 2009 left shoulder x-ray showed degenerative joint disease with supraspinatus calcific tendinitis or calcific bursitis. A March 25, 2009 carotid ultrasound demonstrated no hemodynamically significant carotid arterial stenosis. Left vertebral artery flow was not seen. In an April 2, 2009 treatment note, Dr. Beck reported findings of poor muscle tone and kyphosis of the cervical spine, left shoulder tenderness, sacroiliac pain and crepitus in all joints. She diagnosed cervical disc disease, anxiety, neck pain, fatigue and malaise and chronic obstructive pulmonary disease (COPD). A May 23, 2009 bilateral hip x-ray showed degenerative joint disease.

A May 25, 2009 emergency room report noted a history of a fall with complaints of chest and back pain. Physical findings included a chin laceration and tenderness of the neck, chest and lumbar spine. Diagnoses were concussion with loss of consciousness; contusions to the face, elbows and pelvis and lumbosacral strain. A May 25, 2009 pelvis x-ray showed no fracture or dislocation and lumbar spine films demonstrated mild scoliosis and degenerative disc disease without fracture or subluxation. Left elbow x-ray was unremarkable. Computerized tomography (CT) scan of the head was normal and CT scan of the cervical spine showed extensive postsurgical findings without evidence of an acute superimposed fracture or loosening. A chest x-ray revealed some COPD findings.

In a June 4, 2009 report, Dr. Beck noted that appellant had fallen when she tripped on the stairs and was seen in the emergency room. She provided physical examination findings, advised that appellant's condition was stable and that she should continue her medication regimen. In June 19, 2009 reports, Dr. Marc O. Anderson, a Board-certified family physician, noted her medical history. He advised that on examination her neck was supple and extremities unremarkable. Dr. Anderson diagnosed back pain. A July 8, 2009 emergency room report noted a chief complaint of narcotic and benzo withdrawal. Dr. Ann Burelbach, Board-certified in emergency medicine, diagnosed acute vomiting, narcotic and benzo dependence and chronic pain syndrome.

In a January 27, 2010 report, Dr. A. Al-Sadat, a Board-certified neurologist, noted appellant's medical and surgical history and a six-month history of jerky movements of the arms and legs several times a day, joint pain and stiffness, frequent headaches and difficulty walking.

[8] She again requested reconsideration on April 7, 2010 and submitted a number of treatment notes from a pain clinic dated June 5 to August 12, 2008 signed by physician's assistants and nurse practitioners dated July 23, 2008 to May 18, 2010.

He advised that she was not experiencing difficulty speaking or swallowing, had no coordination/balancing issues, sensory changes or memory loss. Dr. Al-Sadat provided physical examination findings, noting full strength and slightly decreased sensation to vibration in the feet. He stated that appellant was able to adequately perform finger-to-nose, fine-finger movements and rapidly alternative movements and had a normal stance, lift, stride and placement and could tandem, heel and toe walk. Romberg test was negative. Dr. Al-Sadat advised that the jerky movements were consistent with myoclonic jerks and could be related to epileptic myoclonus, myoclonus related to a metabolic cause, medication induced or originating from a spinal cord injury. He recommended additional testing to include a brain MRI scan, electroencephalography, CT scan of the cervical spine and electromyography of the upper extremities. Cervical spine CT scan on February 11, 2010 demonstrated incomplete bony union at C3-4 of questionable significance and postsurgical changes.

By report dated March 22, 2010, Dr. Welling noted appellant's complaints of pain in the occipital region, neck, low back, left shoulder, both arms, both hands and both legs, with right and left upper extremity weakness and numbness and multiple complaints involving all body systems. He reviewed the medical and surgical history and noted that physical examination demonstrated four to five upper extremity muscle strength and atrophy in both upper extremities. Sensation at C5, C8 and T1 was normal and decreased to pinprick at C6 and C7. Gait and bilateral toe and heel walk were normal. Range of motion in the cervical spine was decreased. Lumbar and bilateral upper and lower extremity range of motion were normal. The cervical area was tender to palpation. Dr. Welling diagnosed shoulder pain, cervical disc degeneration and cervical radiculopathy. He recommended x-rays and MRI scan of the cervical spine. March 24, 2010 x-rays of the cervical spine demonstrated a solid bony fusion at C4-7 and asymmetric narrowing on the left at C2-3. MRI scan of the cervical spine demonstrated surgical fusion at C3-7 and asymmetric left-side neural foraminal narrowing at C2-3.

On April 27, 2010 Dr. Grace O'Brien, an osteopath, noted appellant's complaint of back and neck pain. She provided physical examination findings of antalgic gait, tenderness and severe pain on motion of the left shoulder, cervical and lumbar spines.

By decision dated June 17, 2010, OWCP denied modification of the April 29, 2009 wage-earning capacity determination.

LEGAL PRECEDENT

OWCP procedures provide that, if a formal loss of wage-earning capacity decision has been issued, the rating should be left in place unless the claimant requests resumption of compensation for total wage loss. In that instance OWCP will need to evaluate the request according to the customary criteria for modifying a formal loss of wage-earning capacity.[9] For modification of a formal loss of wage-earning capacity the evidence must establish: (1) the original rating was in error; (2) the claimant's medical condition has changed; or (3) the claimant

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reemployment: Determining Wage-Earning Capacity*, Chapter 2.814.9(a) (December 1995).

has been vocationally rehabilitated. The party seeking modification of a formal loss of wage-earning capacity decision has the burden to prove that one of these criteria has been met.[10]

Once OWCP accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[11] An injured employee who is either unable to return to the position held at the time of injury or unable to earn equivalent wages, but who is not totally disabled for all gainful employment, is entitled to compensation computed on loss of wage-earning capacity.[12] Section 8115 and the implementing federal regulations provide that wage-earning capacity is determined by the actual wages received by an employee if the earnings fairly and reasonably represent his or her wage-earning capacity. If the actual earnings do not fairly and reasonably represent wage-earning capacity or the employee has no actual earnings, his or her wage-earning capacity is determined with due regard to the nature of the injury, the degree of physical impairment, usual employment, age, qualifications for other employment, the availability of suitable employment and other factors or circumstances which may affect his or her wage-earning capacity in the disabled condition.[13]

When OWCP 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 OWCP for selection of a position listed in the DOT or otherwise available in the open market, that fits that employee's capabilities with regard to his or her physical limitations, 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.[14] Finally, application of the principles set forth in *Albert C. Shadrick*[15] will result in the percentage of the employee's loss of wage-earning capacity.[16]

ANALYSIS

The Board finds that appellant did not submit sufficient evidence to show that the April 29, 2009 wage-earning capacity determination was erroneous.[17] There is no evidence of record that the decision was in error or that she was retrained or otherwise vocationally rehabilitated and the medical evidence submitted is insufficient to show that there was a material change in the nature and extent of the injury-related conditions.

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[10] *Id.* at Chapter 2.814.11 (June 1996); *see Stanley B. Plotkin*, 51 ECAB 700 (2000).

[11] *James M. Frasher*, 53 ECAB 794 (2002).

[12] 20 C.F.R. §§ 10.402, 10.403; *John D. Jackson*, 55 ECAB 465 (2004).

[13] 5 U.S.C. § 8115; 20 C.F.R. § 10.520; *John D. Jackson, id.*

[14] *James M. Frasher, supra* note 11.

[15] 5 ECAB 376 (1953); *see also* 20 C.F.R. § 10.403.

[16] *James M. Frasher, supra* note 11.

[17] *Katherine T. Kreger*, 55 ECAB 633 (2004); *Sharon C. Clement*, 55 ECAB 552 (2004); Federal (FECA) Procedure Manual, *supra* note 9.

The accepted conditions in this case are cervical and left shoulder strains, herniated disc at C5-6 and left rotator cuff tendinitis. By decision dated April 29, 2009, OWCP adjusted appellant's compensation, based on her capacity to earn wages as cashier, parking booth attendant. It found that the weight of the medical evidence was represented by the reports of Dr. Giovanniello, who based his opinion regarding her physical capabilities on a November 20, 2007 functional capacity evaluation and on the opinion of Dr. Burns, who provided psychological test results and advised that appellant's verbal learning, memory, visuospatial ability, attention and language, fell within the average to superior range.

On January 20, 2010 appellant requested reconsideration. While she asserted that she had a stroke on July 11, 2008 and was taken to the emergency room, she submitted no probative medical evidence, such as an emergency room report or physician's opinion that this occurred. The only evidence of record that discusses appellant's assertion is an August 28, 2008 letter from Mr. Henry, a physician's assistant, who stated that she had sustained a series of strokes, with the initial event occurring on July 13, 2008. Medical evidence from a nurse practitioner or physician's assistant is not considered probative evidence as these persons are not considered physicians under FECA[18] and the date of the claimed event in her correspondence does not agree with that in his report.

In a January 27, 2010 report, Dr. Al-Sadat described a six-month history of jerky movements and difficulty speaking. While he noted appellant's report of a stroke in 1995, he did not note a history of strokes in July 2008. Dr. Al-Sadat advised that on examination she had no coordination or balancing issues and no sensory changes or memory loss. He stated that appellant was able to adequately perform finger-to-nose, fine-finger movements and rapidly alternative movements and had a normal stance, lift, stride and placement and could tandem, heel and toe walk. Romberg test was negative. Dr. Al-Sadat opined that the jerky movements were consistent with myoclonic jerks and could be related to epileptic myoclonus, myoclonus related to a metabolic cause, medication induced or originating from a spinal cord injury and recommended additional testing. He did not discuss appellant's physical limitations or her ability to perform the duties of the constructed position. Hence, Dr. Al-Sadat's report is of little probative value on the issue of whether her condition had changed such that she could no longer perform the duties of the selected position.[19]

Appellant submitted additional medical reports including those of Dr. Beck, Dr. Welling, Dr. Anderson, Dr. O'Brien and emergency room physicians. While each physician described her complaints of chronic pain and described physical examination findings, none provided an opinion that her condition had worsened or an opinion regarding her work capabilities.

The Board finds that, as the medical evidence did not establish a material change in the nature and extent of the injury-related conditions, it is insufficient to establish that the April 29,

[18] *Sean O'Connell*, 56 ECAB 195 (2004). Section 8101(2) of FECA provides that "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. 5 U.S.C. § 8101(2); *see Roy L. Humphrey*, 57 ECAB 238 (2005).

[19] *See Darletha Coleman*, 55 ECAB 143 (2003).

2009 wage-earning capacity decision should be modified.[20] OWCP therefore properly denied modification of the April 29, 2009 wage-earning capacity determination.[21]

Appellant may request modification of the wage-earning capacity determination, supported by new evidence or argument, at any time before OWCP.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that an April 29, 2009 wage-earning capacity decision that reduced her compensation should be modified.

ORDER

IT IS HEREBY ORDERED THAT the June 17, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 17, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[20] *Id*.

[21] *T.M.*, Docket No. 08-975 (issued February 6, 2009).