United States Department of Labor
Employees' Compensation Appeals Board

A.J., Appellant	)	
	)	
and	)	**Docket No. 10-2162**
	)	**Issued: July 1, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Pittsburgh, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 16, 2010 appellant, through her representative, filed a timely appeal of a July 27, 2010 merit decision of the Office of Workers' Compensation Programs which denied her claim for disability compensation. Pursuant to the Federal Employees' Compensation Act[1] 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 was disabled from September 16 to November 1, 2009 due to her September 14, 2009 employment injury and therefore entitled to continuation of pay or wage-loss compensation benefits.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 25, 2009 appellant, then a 59-year-old patient services assistant, filed a traumatic injury claim alleging that on September 14, 2009 she sustained injuries to her chest, lower back and knees when a file cabinet fell on her at work. The employing establishment controverted her claim alleging that she was personally reacting to a prior claim that was denied and to a new temporary worker that was hired to relieve her of her telephone and e-mail duties. It also stated that a coworker observed appellant standing on a stool to access the cabinet and advised her that it was unsafe.

In a letter dated October 7, 2009, the Office advised appellant that the evidence received was insufficient to support her claim and requested additional information. It requested that she describe how the injury occurred and its immediate effects, provide statements from any witnesses and explain why she delayed seeking medical attention. The Office also requested appellant to submit a narrative medical report which included a history of injury, firm diagnosis, findings, test results, treatment provided, prognosis, period and extent of disability and a physician's opinion, based on medical rationale, explaining why the diagnosed condition was believed to have been caused or aggravated by her claimed injury.

In a September 14, 2009 employee health record, an unknown provider stated that a file cabinet fell onto appellant's chest, torso and legs pinning her to the desk at work. In an emergency room report, Denise R. Ulizio, a physician's assistant, noted appellant complaints of a work injury that caused musculoskeletal chest, back, hip pain and knee pain. Appellant stated that she was looking for a chart in the top drawer of a file cabinet when the file cabinet toppled forward and trapped her on her desk until several men were able to lift her free. X-rays revealed mild bilateral hyperinflated lungs and senescent changes of the spine but no active infiltrate, pleural effusion or pulmonary edema.

Appellant submitted medical reports dated October 20, 2009 from Dr. Brent Clark, a Board-certified family practitioner. In a work capacity evaluation form, Dr. Clark noted that she was not capable of performing her usual job until November 1, 2009. In an attending physician's report, he reported that he first examined appellant on October 5, 2009. Dr. Clark stated that on September 14, 2009 a cabinet fell on her and he diagnosed her with a lumbar strain and chest contusion. He also checked a box marked "yes" that appellant's medical condition was caused or aggravated by the work event. Dr. Clark noted that she was disabled from September 14 to November 1, 2009 and authorized her to resume light duty on November 1, 2009.

Appellant also submitted several hospital records. In a September 14, 2009 report, Dr. Kevin Semelrath, an emergency medicine physician, reported that a file cabinet fell on her and pinned her to her desk. Appellant complained of chest pain, especially with deep inspiration and bilateral knee pain. Dr. Semelrath reviewed her medical and social history, conducted an examination and diagnosed appellant with a chest wall injury.

In a September 15, 2009 hospital report, Dr. Jason Chang, Board-certified in emergency medicine, provided a history of injury that appellant was crushed in between a desk and file cabinet that fell on her at work and noted her complaints of diffuse pain throughout her chest and neck. Upon examination, he noted that her head and neck showed no evidence of any gross

traumatic injuries and her airway was intact with good air entry bilaterally. Dr. Chang also did not observe any palpitations, shortness of breath, nausea, vomiting or neurological deficits. An x-ray also did not reveal any significant traumatic injuries. Dr. Chang recommended computerized tomography (CT) scans, but opined that it was unlikely that appellant sustained any significant injuries. In an addendum, he stated that appellant underwent multiple CT scans and tested negative for any significant injuries and acute traumatic injuries. Dr. Chang diagnosed her with multiple contusions and stated that she could most likely be discharged tomorrow.

In a September 16, 2009 hospital discharge report, Dr. Gary T. Marshall, a Board-certified surgeon, stated that appellant was admitted on September 14, 2009 after a file cabinet fell on her and pinned her to her desk at work. He noted that her complaints of chest pain, especially with deep inspiration and bilateral knee pain. Upon examination, Dr. Marshall noted slight tenderness to her chest, but no crepitus. Appellant's focused assessment with sonography for trauma examination and x-rays were both negative. Dr. Marshall also reviewed her various CT scans and reported that her chest, abdomen, pelvis, thoracic and lumbar spine scans were also negative. Appellant's head CT scan revealed possible punched out lytic bone lesions of her temporal bones consistent with possible myeloma and her C-spine CT scan showed degenerative joint disease but no signs of trauma. She was admitted for evaluation and discharged on September 15, 2009. Appellant also provided the diagnostic CT scan results dated September 14, 2009.

In a September 15, 2009 progress note, Dr. David J. McAdams, a Board-certified internist, examined appellant and diagnosed her with a bone neoplasm of her skull. In another September 24, 2009 consultation report, he provided a history of injury that a file cabinet fell on her at work, which caused her significant chest pain. Dr. McAdams reviewed appellant's medical and social background, conducted an examination and recommended that she undergo a full skeletal survey to check for other lytic lesions. On September 15, 2009 appellant underwent a complete bone survey by Dr. Saraswathi K. Golla, a Board-certified diagnostic radiologist, which revealed a lytic lesion in her right posterior parietal bone.

On November 13, 2009 the Office accepted appellant's claim for contusion of chest wall but denied continuation of pay for the period September 16 to November 1, 2009. It noted that she returned to work on November 2, 2009 but determined that the medical evidence was insufficient to establish that she was disabled due to her accepted employment injury for the period September 16 to November 1, 2009.

On November 24, 2009 appellant filed a Form CA-7 claim for compensation for the period September 16 to November 1, 2009.

On November 26, 2009 appellant requested an oral hearing before the Branch of Hearings and Review and resubmitted her emergency room hospital records. On December 3, 2009 appellant, through her representative, requested an oral hearing before the Branch of Hearings and Review.

In a letter dated December 7, 2009, the Office advised appellant that the medical evidence was insufficient to support that she was disabled for the period September 16 to

November 1, 2009 due to her accepted work injury. Appellant resubmitted her hospital records, medical reports and diagnostic results dated September 14 to 16, 2009.

In a February 2, 2010 decision, the Office denied appellant's claim for compensation for the period September 16 to November 1, 2009 on the grounds of insufficient medical evidence demonstrating that she was disabled from work during the claimed time period.

On February 16, 2010 appellant, through her representative, appealed the February 2, 2010 decision and requested a telephone hearing which was held on April 19, 2010. She was represented by Attorney Alan J. Shapiro. Appellant stated that on the morning of September 14, 2009 she was collecting employee files from the file cabinet and when she pulled out the second cabinet, it opened up so fast that it tilted on her. She explained that the cabinet pinned her against her desk and she had to call out for help. Appellant complained of chest pains and was eventually diagnosed with chest contusions. She also stated that she was off work for no more than 45 days. Appellant further reported that she went to see a private doctor who reevaluated her and advised her to remain off work a little longer because she complained about back and chest pain, which made it difficult to breathe. She noted that her physician, Dr. Clark, authorized her to remain off work and told her that he would take care of the coverage. The hearing representative informed appellant that the OWCP-5 form from Dr. Clark was insufficient to establish her claim because it did not explain why she needed to remain off work. Appellant requested 30 days to submit additional medical evidence.

Appellant resubmitted her hospital records, medical reports and diagnostic results dated September 14 to 16, 2009.

By decision dated July 27, 2010, the Office hearing representative denied appellant's claim for disability compensation for the period September 16 to November 1, 2009 because the record did not contain any evidence establishing that appellant was disabled from work during the claimed period of time as a result of her accepted employment injury.

LEGAL PRECEDENT

Section 8118 of the Act provides for the continuation of pay for an employee who has properly filed a claim for a period of wage loss due to traumatic injury.[2] Office regulations implementing the Act state that an employee who sustains a disabling, job-related traumatic injury is entitled to the continuation of his or her regular pay for a period not to exceed 45 days.[3] The regulations also provide that an employee applying for continuation of pay must provide medical evidence supporting disability resulting from the claimed traumatic injury. The employee must also ensure that the treating physician specifies work limitations and provides them to the employer and/or the Office.[4]

[2] 5 U.S.C. § 8118.

[3] 20 C.F.R. § 10.200(a).

[4] *Id*. at § 10.210(b)-(d).

The term disability means incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of the injury.[5]

The Board will not require the Office to pay compensation for disability in the absence of medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so, would essentially allow an employee to self-certify their disability and entitlement to compensation.[6]

ANALYSIS

The Office accepted that appellant sustained a contusion of her chest wall in the performance of duty on September 14, 2009. Appellant filed a claim for continuation of pay from September 16 to November 1, 2009 and in the alternative filed a claim for disability compensation benefits. The Office denied her claim on the grounds of insufficient medical evidence demonstrating that she was disabled for the claimed period of disability.

Appellant provided hospital records and diagnostic results dated September 14 to 16, 2009 from Drs. Semelrath, Chang, Marshall, Saraswathi and McAdams. These reports accurately described her history of injury and noted her chest wall injury. None of the reports, however, indicate whether appellant was disabled as a result of her September 14, 2009 employment injury or mention any specific dates or period of disability. These doctors do not offer any opinion on appellant's ability to work and whether she was disabled for the claimed period. These reports, therefore, fail to demonstrate that she was disabled for the claimed period due to her September 14, 2009 work injury.[7]

The only medical reports addressing appellant's period of disability are the reports from Dr. Clark dated October 20, 2009. In a work capacity evaluation form, Dr. Clark stated that appellant was not capable of performing her usual job until November 1, 2009. While this form indicated that light duty was available for appellant and required that specific limitations be noted for activities including sitting, walking, standing, reaching, driving, etc., he did not note appellant's specific limitations, but rather indicated that she could perform work for zero hours a day. Dr. Clark also stated in an attending physician's report that appellant was disabled from September 14 to November 1, 2009 and could resume light duty on November 1, 2009. He, however, did not provide any medical explanation as to why appellant had limitations on all activities and was totally disabled. In addition, the Office hearing representative advised appellant during her telephone hearing that Dr. Clark's reports were insufficient to establish her claim because he failed to explain why she was disabled from work. As Dr. Clark's reports fail to address whether appellant's disability from September 14 to November 1, 2009 was causally related to her accepted employment injuries, these reports are insufficient to establish her claim.

[5] *S.M.*, 58 ECAB 166 (2006); *Bobbie F. Cowart*, 55 ECAB 746 (2004); *Conrad Hightower*, 54 ECAB 796 (2003); 20 C.F.R. § 10.5(f).

[6] *Alfredo Rodriguez*, 47 ECAB 437 (1996).

[7] *See K.S.*, Docket No. 10-1445 (issued March 23, 2011); *J.H.*, Docket No. 10-1165 (issued February 1, 2011).

Appellant also submitted a hospital record by a physician's assistant. A physician's assistant, however, is not considered a "physician" as defined under the Act.[8] Accordingly, this report is of no probative value and does not constitute competitive medical evidence sufficient to establish appellant's claim.

As previously stated, it is appellant's burden to establish that any disability is causally related to the accepted employment injury.[9] The Board finds that there is insufficient medical opinion to establish that appellant was disabled from September 16 to November 1, 2009 as a result of her accepted chest wall contusion. Thus, appellant did not meet her burden of proof to establish her claim for disability compensation.[10]

CONCLUSION

The Board finds that appellant did not establish that she was totally disabled from September 16 to November 1, 2009 due to her accepted September 14, 2009 employment injury.

[8] *E.H.*, Docket No. 08-1862 (issued July 8, 2009); *S.E.*, Docket No. 08-2214 (issued May 6, 2009); 5 U.S.C. § 8101(2) of the Act provides as follows: "(2) 'physician' includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law."

[9] *S.S.*, 59 ECAB 315 (2008); *M.B.*, Docket No. 10-1401 (issued March 17, 2011).

[10] The Board notes that appellant submitted additional evidence following the July 27, 2010 decision. Since the Board's jurisdiction is limited to evidence that was before the Office at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c); *Sandra D. Pruitt,* 57 ECAB 126 (2005).

ORDER

IT IS HEREBY ORDERED THAT the July 27, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 1, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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