



## **FACTUAL HISTORY**

On July 5, 2006 appellant, then a 48-year-old air traffic control specialist, filed an occupational disease claim alleging anxiety, depression, panic attacks and cardiomyopathy related to his federal employment. In November 2004, he had an operational error and in April 2005 he had a close call involving an aircraft. After these two incidents, appellant was not as confident as he used to be. In August 2005, while training a person, he experienced an episode of sweating and his heart beating very fast such that he had to leave the control room. The employing establishment stated on the claim form that, after August 31, 2005, appellant was assigned temporary administrative-type duties due to medical restrictions imposed by the flight surgeon.

On September 8, 2005 Dr. David Stewart, a Board-certified internist with a subspecialty in cardiovascular disease, performed a single day dual isotope myocardial perfusion study. He listed his impressions as an abnormal treadmill study with evidence of left ventricular dilation, but no definite segmental ischemia and abnormal left ventricular systolic function.

On September 26, 2005 appellant saw Dr. Keith G. Anderson, a Board-certified internist certified in the subspecialties of cardiovascular disease and interventional cardiology. He complained of an abnormal echocardiogram (EKG). Dr. Anderson noted that, one month prior, appellant had an episode of lightheadedness and diaphoresis. Appellant also experienced chronic fatigue, moderate weight gain intermittent headaches and heart palpitations. Dr. Anderson stated that appellant had brief hemoptysis which he attributed to an upper respiratory tract infection. Appellant also had intermittent dyspepsia and multiple joint pains with some intermittent lower extremity edema while at work. Dr. Anderson also found chronic anemia which was associated with his lymphoma. He listed his impression as dilated cardiomyopathy possibly related to non-Hodgkin's lymphoma chemotherapy, presently compensated clinically.

In an October 3, 2005 report, Dr. Anderson noted that appellant underwent a cardiac cauterization which confirmed fairly severe global hypokinesis with an ejection fraction (EF) of 30 to 35 percent. He stated that appellant had moderate coronary artery disease, but there were no critical lesions and his cardiomyopathy was out of proportion to his coronary artery disease. Dr. Anderson noted that it was unlikely that his coronary artery disease accounted for the cardiomyopathy itself. On March 13, 2006 he advised that appellant underwent surveillance EKG, which demonstrated improvement of his left ventricular ejection fraction which was now 44 percent. On June 7, 2006 Dr. Anderson noted that appellant's dilated cardiomyopathy was not caused by his work but might be aggravated, exacerbated or complicated by his current job.

Appellant took medical retirement as of May 9, 2006.

On June 30, 2006 appellant underwent selective renal angiography and bilateral renal angioplasty stenting.

On July 20, 2006 appellant reiterated that, in late August 2005, while training a person with his supervisor monitoring, he had an episode which included heart racing dizziness, sweating and a strong urge to leave the area. He went home and made an appointment with his family doctor who obtained an abnormal EKG. Appellant was referred to a psychiatrist, who

told him that his depression and stress had a link to his heart disease. He contended that the stress from his job for almost 22 years contributed to his heart condition. Appellant acknowledged that he smoked for the prior six years, less than a pack a day, and that he smoked a pack a day from 1982 to 1990.

In a September 26, 2006 report, Dr. Anderson stated that appellant suffered from a nonischemic dilated cardiomyopathy. While the cause of this condition was unknown and not specifically related to appellant's employment, his condition was exacerbated and aggravated by exposure to employment as an air traffic controller. Dr. Anderson noted that appellant's prognosis was related to the degree of heart failure from which he suffered. Appellant's status was presently Class II congestive heart failure and if his prognosis worsened it would require hospitalization for treatment. Dr. Anderson opined that exposure to employment as an air traffic controller substantially increased appellant's risk for decompensation and adversely impacted his prognosis. Appellant was on multiple medications which he would need to take indefinitely, as his condition was not curable. The medications lowered his blood pressure substantially. Dr. Anderson advised that exposure to full-time employment as an air traffic controller may not be compatible with these medications. In a November 9, 2006 response to questions from the Office, he stated that appellant had nonischemic dilated cardiomyopathy of undetermined etiology. Dr. Anderson indicated that the exact cause of this condition would never be determined. He reviewed the description of appellant's job as an air traffic controller, and stated: "The chronic job stress associated with being air traffic controller CAUSES decompensation of his nonischemic dilated cardiomyopathy resulting in recurrent bouts of heart failure." (Emphasis in the original.) Dr. Anderson recommended that appellant no longer participate in air traffic controlling.

On May 18, 2007 the Office accepted appellant's claim for aggravation of major depression.

On September 27, 2007 the Office referred appellant to Dr. Kishore Kumar Arcot, a Board-certified internist specialist in cardiovascular disease and interventional cardiology, for a second opinion. On October 11, 2007 Dr. Arcot reviewed appellant's medical history. He noted that appellant's cardiomyopathy may be ischemic or nonischemic. Dr. Arcot stated that to his knowledge there was no association with work-related stress as a cause for dilated cardiomyopathy. Appellant had multiple risk factors for coronary atherosclerosis, including hypercholesterolemia and a history of chronic smoking. He also had peripheral vascular disease with a significant documented coronary atherosclerosis.

In a February 8, 2008 note, Dr. Anderson found that appellant could perform a sedentary job for eight hours a day with limits of minimizing emotional and physical stress that could cause his cardiac condition to deteriorate. Appellant had reached maximum medical improvement with respect to the August 31, 2005 illness.

The Office found a conflict in medical opinion between Dr. Anderson and Dr. Arcot with regard to whether appellant's current cardiac condition was causally related to the August 31, 2005 employment injury. On February 25, 2008 it referred appellant to Dr. Matthew Smolin, a Board-certified internist in the subspecialties of cardiovascular disease and interventional cardiology. In a March 14, 2008 report, Dr. Smolin reviewed appellant's history of medical

treatment and conducted an echocardiogram and nuclear stress test. He noted appellant's history was positive for hypertension and hyperlipidemia. Dr. Smolin diagnosed idiopathic dilated cardiomyopathy, mild in severity. By idiopathic, he meant that the etiology of the cardiomyopathy was undetermined. Dr. Smolin did not believe that there was any evidence for ischemic cardiomyopathy or for myocardial scarring. He also noted mild atherosclerotic heart disease; palpitations; dyspnea and chest pain with no objective evidence of ischemia; hypertension; hyperlipidemia. Appellant had a history of non-Hodgkin's lymphoma, postchemotherapy and radiation therapy as well as a bone marrow transplant with no evidence of disease. Appellant was a smoker, ongoing, with an undetermined psychiatric illness as diagnosed and treated by Dr. Juan Javamillo. Dr. Smolin noted that appellant's only current symptoms with regard to the August 31, 2005 incident were heart palpitations. He noted that appellant's EF had improved when compared to his initial evaluations in 2005. Dr. Smolin advised that the etiology and duration of the dilated cardiomyopathy was unknown. He opined that the palpitations that appellant experienced on August 31, 2005 were likely the result of appellant's cardiomyopathy aggravated by the stress of his employment. However, Dr. Smolin did not believe that the cardiomyopathy itself was the result of the employment. He opined that appellant had recovered from any temporary aggravation of his cardiomyopathy by November 2007. Dr. Smolin found that appellant's prognosis was excellent. He attached results from the stress test and myocardial perfusion imaging study, which noted normal wall motion with an ejection fraction of 53 percent and no definite evidence of ischemia.

By decision issued May 16, 2008, the Office accepted appellant's claim for a temporary aggravation of cardiomyopathy from August 31, 2005 through November 30, 2007. In a separate decision dated May 16, 2008, it terminated appellant's medical and compensation benefits effective November 30, 2007 because the medical evidence established that he no longer had any residuals or disability due to the temporary aggravation.

On June 11, 2008 appellant requested an oral hearing, by telephonic hearing. In a July 1, 2008 letter, the Office acknowledged receipt of the oral hearing request. By letter dated August 22, 2008, it sent appellant notification that a telephonic hearing would be held on September 26, 2008 at 1:00 pm. The letter provided the toll free number and pass code for the hearing. The letter was addressed to appellant's address of record.

In an October 6, 2008 decision, the Office found that appellant abandoned his request for a hearing. It noted that a hearing was scheduled for September 26, 2008, that he received proper notice of the hearing, but that failed to call the Office as directed on the date of the hearing, or subsequently contact the Office to provide the reasons for his failure to appear.

### **LEGAL PRECEDENT -- ISSUE 1**

Once the Office accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.<sup>1</sup> Having determined that an employee has a disability causally related to his federal employment, the Office may not terminate compensation without

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<sup>1</sup> *T.F.*, 58 ECAB \_\_\_\_ (Docket No. 06-1186, issued October 19, 2006); *George A. Rodriguez*, 57 ECAB 224 (2005).

establishing either that the disability has ceased or that it is no longer related to the employment.<sup>2</sup> The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.<sup>3</sup> To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.<sup>4</sup> The fact that the Office accepts a claim for a specified period of disability does not shift the burden of proof to the employee to show he or she is still disabled.<sup>5</sup>

Under the Federal Employees' Compensation Act, when employment factors cause an aggravation of an underlying condition, the employee is entitled to compensation for the periods of disability related to the aggravation. When the aggravation is temporary and leaves no permanent residuals, compensation is not payable for periods after the aggravation has ceased, even if the employee is medically disqualified from continuing employment due to the underlying condition.<sup>6</sup>

Section 8123(a) of the Act provides in pertinent part: If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.<sup>7</sup> Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.<sup>8</sup>

### ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for temporary aggravation of his cardiomyopathy from August 31, 2005 through November 30, 2007. It terminated his compensation benefits for this condition as of November 30, 2007 finding that the medical evidence established that he did

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<sup>2</sup> *J.M.*, 58 ECAB \_\_\_\_ (Docket No. 06-661, issued April 25, 2007); *Elaine Sneed*, 56 ECAB 373 (2005).

<sup>3</sup> *E.J.*, 59 ECAB \_\_\_\_ (Docket No. 08-1350, issued September 8, 2008); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Furman G. Peake*, 41 ECAB 361 (1990).

<sup>4</sup> *I.J.*, 59 ECAB \_\_\_\_ (Docket No. 07-2362, issued March 11, 2008); *T.P.*, 58 ECAB \_\_\_\_ (Docket No. 07-60, issued May 10, 2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

<sup>5</sup> See *Dawn Sweazy*, 44 ECAB 824 (1993).

<sup>6</sup> See *Raymond W. Behrens*, 50 ECAB 221 (1999).

<sup>7</sup> 5 U.S.C. § 8123(a); see also *Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

<sup>8</sup> *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Gary R. Sieber*, 46 ECAB 215 (1994).

not have any residuals or disability after that date.<sup>9</sup> It is the Office's burden to demonstrate that his disability ceased or was no longer employment related.<sup>10</sup>

Dr. Anderson opined that appellant's job stress associated with working as an air traffic controller caused decompensation of his nonischemic dilated cardiomyopathy resulting in recurrent bouts of heart failure. The second opinion physician, Dr. Arcot, found that there was no association between work-related stress and dilated cardiomyopathy. He noted that appellant had multiple risk factors for coronary atherosclerosis including hypercholesterolemia and history of chronic smoking. Appellant also had peripheral vascular disease with a significant association for coronary artery disease. As there was a conflict between the opinion of appellant's treating physician and that of the second opinion physician with regard to whether appellant's cardiac condition was caused by his employment, the Office properly referred him to Dr. Smolin for an impartial medical examination.

In a report dated March 14, 2008, Dr. Smolin noted mild atherosclerotic heart disease, palpitations, dyspnea and chest pain with no objective evidence of ischemia, hypertension and hyperlipidemia. He noted that the etiology and duration of the dilated cardiomyopathy were unknown. Dr. Smolin opined that the heart palpitations that appellant experienced on August 31, 2005 were likely the result of his underlying cardiomyopathy aggravated by the stress of his employment. He did not find evidence that the cardiomyopathy itself was the result of appellant's federal employment. Dr. Smolin also noted that appellant recovered from the temporary aggravation of his cardiomyopathy by November 2007. He based this on the fact that the documented change in appellant's condition on diagnostic testing since 2005 has been favorable with substantial recovery of his ejection fraction, such that he was substantially recovered by November 2007.

The Board finds that the opinion of Dr. Smolin, a Board-certified cardiologist selected for the purpose of resolving the conflict in opinion, is entitled to special weight.<sup>11</sup> Dr. Smolin's opinion is based on an accurate factual and medical history, and a detailed examination and diagnostic tests. He found that appellant's cardiomyopathy was aggravated by the stress of his employment but that appellant recovered from this temporary aggravation by November 2007. Based on this report, the Office properly accepted appellant's claim for a temporary aggravation of his cardiomyopathy from August 31, 2005 through November 30, 2007 and appropriately found that this aggravation ceased after November 30, 2007. Accordingly, the Board finds that the Office properly terminated appellant's compensation and medical benefits for aggravation of cardiopathy as of November 30, 2007.

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<sup>9</sup> The Board notes that the Office also accepted appellant's claim for aggravation of major depression and is paying appropriate benefits for this condition. The fact that the Office is paying benefits with regard to his depression is not affected by the termination of benefits with regard to his cardiac condition.

<sup>10</sup> See *Dawn Sweazy*, *supra* note 5.

<sup>11</sup> *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

## LEGAL PRECENT -- ISSUE 2

A claimant who has received a final adverse decision by the Office may obtain a hearing by writing to the address specified in the decision within 30 days of the date of the decision for which a hearing is sought.<sup>12</sup> Unless otherwise directed in writing by the claimant, the Office hearing representative will mail a notice of the time and place of the hearing to the claimant and any representative at least 30 days before the scheduled date.<sup>13</sup> Chapter 2.1601.6(e) of the Office's procedure manual, dated January 1999, provides as follows:

“e. Abandonment of Hearing Requests.

(1) A hearing can be considered abandoned only under very limited circumstances. All three of the following conditions must be present: the claimant has not requested a postponement; the claimant has failed to appear at a scheduled hearing; and the claimant has failed to provide any notification for such failure within 10 days of the scheduled date of the hearing.

Under these circumstances, H&R [the Branch of Hearings and Review] will issue a formal decision finding that the claimant has abandoned his or her request for a hearing and return the case to the DO [district Office].”<sup>14</sup>

## ANALYSIS -- ISSUE 2

In the present case, the Office sent notice that the telephonic hearing would be held on September 26, 2008 at 1:00 pm to appellant's address of record. It also sent him instructions as to how to connect with the telephonic hearing. This notice was not returned as undeliverable. Thus, under the mailbox rule, the presumption is that appellant received proper notification of his hearing.<sup>15</sup>

There is no evidence that appellant requested a postponement or attempted to telephone the Office hearing representative at the designated time on November 8, 2007. In addition, there is no evidence of record that he provided notification of his failure to participate in the scheduled hearing within 10 days of the scheduled date.

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<sup>12</sup> 20 C.F.R. § 10.616(a).

<sup>13</sup> *Id.* at § 10.617(b).

<sup>14</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Hearing and Reviews of the Written Record*, Chapter 2.1601.6(e) (January 1999).

<sup>15</sup> Under the mailbox rule, a letter properly address and mailed in the due course of business, such as in course of the Office's daily activities, is presumed to have arrived at the mailing address in due course. *See James A. Gray*, 54 ECAB 277 (2002); *Charles R. Hibbs*, 43 ECAB 699 (1992).

The Board accordingly finds that, based on the evidence of record, appellant abandoned his request for a hearing in this case.<sup>16</sup> The Office properly issued a formal decision finding abandonment of the hearing request.

**CONCLUSION**

The Board finds that the Office properly terminated appellant's compensation and medical benefits for aggravation of cardiomyopathy effective November 30, 2007. The Board further finds that the Office properly found that appellant abandoned his request for an oral hearing.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decisions of the Office of Workers' Compensation Programs dated October 6 and May 16, 2008 are affirmed.

Issued: November 24, 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

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<sup>16</sup> See *C.T.*, 60 ECAB \_\_\_ Docket No. 08-2160, issued May 7, 2009).