United States Department of Labor
Employees' Compensation Appeals Board

T.H., claiming as widow of M.H., Appellant	)	
and	)	**Docket No. 12-1018**
	)	**Issued: November 2, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Van Nuys, CA, Employer	)	

Appearances:
Steven E. Brown, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 16, 2012 appellant, through her representative, filed a timely appeal from the October 17, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied survivor benefits. 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. The Board also has jurisdiction to review OWCP's April 6, 2012 nonmerit decision denying reconsideration.

ISSUES

The issues are: (1) whether the employee's death in 2009 was causally related to his accepted acute myocardial infarction in 1982; and (2) whether OWCP properly denied appellant's reconsideration request.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 15, 1982 the employee, a 55-year-old clerk, sustained a heart attack in the performance of duty. OWCP accepted his claim for acute myocardial infarction.

The employee passed away on March 24, 2009. The certificate of death listed the immediate cause of death as cryptogenic cirrhosis of the liver, nonalcoholic. Appellant filed a claim for compensation by widow, Form CA-5.

Dr. Stanley J. Majcher, a Board-certified internist and consulting physician, reviewed the employee's medical background and death to determine on appellant's behalf whether there was an industrial nexus. He reviewed prior medical reports. Dr. Majcher previously determined that there was an industrial nexus to the employee's medical condition. After he reviewed the employee's discharge record from March 19, 2009, he stated: "The issue of heart disease obviously is clearly recorded as a contributing factor to the decedent's condition."

As the medical records noted, there were multiple factors that contributed to the employee's death, "but an important factor which has been noted repeatedly in the records is heart problems." Dr. Majcher noted that the employee had an acute heart attack that obviously had an adverse impact on his various other internal organ functions and eventually caused death. He concluded that the employee's death was industrially related because OWCP had accepted his heart problems as industrially related and the medical records regarding his death substantiated heart problems as contributing to death.

OWCP referred the case to Dr. Ajit B. Raisinghani, Board-certified in cardiovascular disease and an OWCP medical consultant, to determine whether the accepted condition of acute myocardial infarction caused the employee's death. Dr. Raisinghani reviewed the medical record and certificate of death. The most recent cardiac testing, he noted, was in 1996. There were no records relating to the employee's final hospital admission leading up to his death; but the employee had advanced liver disease. The death certificate noted the primary cause of death as nonalcoholic cryptogenic cirrhosis. No mention was made of any cardiac conditions or diseases being relevant at the time of death.

Based on the data provided and the death certificate, Dr. Raisinghani concluded that liver disease was the primary cause of death. The employee had a history of coronary artery disease, "but what is at issue here is the primary cause of death and based on the death certificate, it was related to his liver disease."

On July 20, 2010 OWCP denied appellant's claim for survivor benefits. It found Dr. Majcher's opinion speculative and lacking sound medical rationale or objective findings. OWCP found that Dr. Raisinghani's opinion held the weight of the medial evidence, as he was a cardiologist who provided substantial medical reasoning.

Appellant, through her representative, requested reconsideration. She argued that the issue was not the primary cause of death but whether the accepted myocardial infarction contributed.

In a February 2, 2011 report, Dr. Thomas E. Diggs, II, Board-certified in cardiovascular disease, noted that the employee had coronary artery disease and sustained a large myocardial infarction in 1982, which caused a significant ischemic cardiomyopathy and an ejection fraction of 36 percent. He noted that a 2008 echocardiogram showed an ischemic cardiomyopathy, decreased left ventricular function, pulmonary hypertension, mitral regurgitation and left atrial enlargement.

Dr. Diggs explained that chronic congestive heart failure with pulmonary hypertension is a well-known cause of liver damage called cardiac cirrhosis due to long-term passive congestion of the liver secondary to the higher pressures in the venous system being reflected back into the inferior vena cava and hepatic veins. The increased venous pressure and venous congestion impairs the efficiency of the hepatocytes causing centro-lobular necrosis and subsequent cirrhosis.

Dr. Diggs noted that Dr. Raisinghani did not offer an opinion on why the employee developed liver disease. The diagnosis of cryptogenic nonalcoholic liver disease implies no definitive cause could be determined pathologically. But as the records showed that the employee had untreated heart failure for years, no other cause of liver cirrhosis could be diagnosed. "In my opinion, cardiac cirrhosis due to the initial myocardial infarction followed by years of congestive heart failure … is the cause of the liver failure and his subsequent death."

On May 3, 2011 OWCP reviewed the merits of appellant's case and denied modification of its prior decision. It found that Dr. Diggs' opinion did not establish a causal relationship between the employee's liver condition and the accepted cardiac condition. OWCP noted that he was not the employee's treating physician. Dr. Diggs' report was submitted at the behest of the appointed representative. There was no indication that he based his opinion on a complete factual and medical history and he only referenced reviewing the report of Dr. Raisinghani. As such, OWCP found Dr. Diggs' opinion of limited probative value. It added that appellant developed his liver condition in the 20 years since he last worked for the postal service and the mere fact that a disease or condition manifests itself years after a period of employment does not raise an inference of causal relationship between the claimed condition and employment.

Appellant again requested reconsideration and submitted the July 12, 2011 supplemental report from Dr. Diggs, who stated that he had reviewed additional medical records, the same medical records to which Dr. Raisinghani referred in his evaluation. Dr. Diggs noted two reports from Dr. Majcher, among other physicians.

Dr. Diggs observed that the employee had an ischemic cardiomyopathy due to the prior heart attack with decreased cardiac function and congestive heart failure. He explained that, with heart failure, the pressures in the venous side of the body are increased. Normal venous pressures are in the range of 0 to 10 millimeters of mercury (mmHg). Normal arterial pressures are in the 120 mmHg range. Because of the increased pressures with the liver veins, congestion develops, which impedes the emptying of the liver. Stasis of blood limits oxygenation of the liver cells leading to cell death and fibrosis (scarring). There is also clotting of the blood within the small liver veins, which exacerbates the problem. Ultimately, Dr. Diggs explained, cirrhosis develops as it did in the employee. He concluded that the cirrhosis must have been present for years prior to the employee's death in 2009.

On October 17, 2011 OWCP reviewed the merits of appellant's case and denied modification of its prior decision. It faulted Dr. Diggs for not mentioning the details or dates of the medical records he identified and for providing only a general overview of what he believed occurred. OWCP held that, in order to establish that this actually occurred in the employee's case, Dr. Diggs would have to discuss all the medical records that establish how the employee's accepted condition specifically caused his death. The evidence received, however, failed this, as the cause of death was cryptogenic cirrhosis of the liver, nonalcoholic.

OWCP found that appellant failed to submit a rationalized medical opinion, based on an accurate factual and medical background, establishing a connection between the employee's death and his accepted medical condition. It further found that no conflict in medical opinion existed that would warrant referral to an impartial medical specialist for resolution.

Appellant, through her representative, requested reconsideration. She argued that Dr. Diggs gave specifics and opined that the situation he described was what happened to the employee. Appellant submitted an additional report from Dr. Diggs, who disagreed with OWCP's October 17, 2011 decision. Dr. Diggs explained that the relationship he previously described does in fact occur. He cited a 1951 study showing 10 percent of patients with long drawn-out cardiac failure develop central and/or intra-lobar fibrosis (cirrhosis). Dr. Diggs asked how the employee developed a liver problem: he had no history of alcohol abuse, chronic viral hepatitis, toxin exposure or congenital metabolic liver abnormalities. For these reasons, it was his opinion that chronically poor heart function resulting from the original heart attack caused the employee's liver problem. Dr. Diggs cited specific medical reports by date and by author showing that the employee had chronic heart damage and poor heart function from the original heart attack, "which can certainly cause or be a major contributor to liver cirrhosis. There is no disputing this fact and there is no other explanation as to why this man suffered from and died from cryptogenic cirrhosis of the liver (nonalcoholic)."

Appellant argued that Dr. Diggs had provided an explanation of the causal relationship between the employee's industrial heart condition and his liver failure, which led to his death. At a minimum, she argued, OWCP should request clarification from its second opinion examiner, request an opinion from its district medical adviser or order an impartial medical specialist to resolve the conflict between Dr. Diggs and the second opinion examiner.

On April 6, 2012 OWCP denied appellant's reconsideration request. It found that Dr. Diggs' report was cumulative and repetitive and did not offer any new medical rationale. OWCP further found that appellant's arguments concerning an impartial medical specialist and not having to prove the primary cause of death were previously considered, they were insufficient to warrant a reopening of the case for a merit review.

On appeal, appellant's representative argues that Dr. Diggs extensively reviewed the same medical records that were in the file and available to the Dr. Raisinghani. He added that Dr. Diggs' later report addressed the issues that OWCP found deficient in its October 17, 2011 decision.

LEGAL PRECEDENT -- ISSUE 1

The United States shall pay compensation for the death of an employee resulting from personal injury sustained while in the performance of duty.[2]

Appellant has the burden of establishing by the weight of the reliable, probative and substantial medical evidence that the employee's death was causally related to an employment injury or to factors of his federal employment. As part of this burden, she must submit a rationalized medical opinion, based upon a complete and accurate factual and medical background, showing a causal relationship between the employee's death and an employment injury or factors of his federal employment.[3] Causal relationship is medical in nature and can be established only by medical evidence.[4]

It is not necessary to prove a significant contribution of employment factors to a condition for the purpose of establishing causal relationship.[5]

Once OWCP starts to procure medical opinion, it must do a complete job.[6] It has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case.[7]

ANALYSIS -- ISSUE 1

When OWCP referred this case to Dr. Raisinghani, Board-certified in cardiovascular disease and an OWCP medical adviser, it asked him to determine whether the accepted condition of acute myocardial infarction caused the employee's death. Dr. Raisinghani did not fully address that question. He concluded that it was not the primary cause of death. Although the employee had a history of coronary artery disease, Dr. Raisinghani stated that the issue was the primary cause of death. Based on the death certificate, the primary cause of death was liver disease. The certificate made no mention of cardiac conditions or diseases being relevant at the time of death.

[2] 5 U.S.C. § 8102(a) (with certain exceptions).

[3] *See Leonora A. Bucco (Guido Bucco)*, 36 ECAB 588 (1985); *Lorraine E. Lamber (Arthur R. Lambert)*, 33 ECAB 1111 (1982).

[4] *Mary J. Briggs*, 37 ECAB 578 (1986); *Ausberto Guzman*, 25 ECAB 362 (1974).

[5] *Beth P. Chaput*, 37 ECAB 158 (1985).

[6] *William N. Saathoff*, 8 ECAB 769 (1956).

[7] *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); *Richard W. Kinder*, 32 ECAB 863, 866 (1981) (noting that the report of OWCP referral physician did not resolve the issue in the case).

As noted, it is not necessary to prove a significant contribution of employment factors to a condition for the purpose of establishing causal relationship. If the medical evidence reveals that a work factor contributed in any way to the employee's condition, the condition is compensable.[8]

Dr. Majcher, the Board-certified internist and consulting physician, supported causal relationship. After reviewing the employee's medical record, he noted that the death certificate did not cover the issue completely, but medical records regarding the employee's death substantiated heart problems as a contributing cause. Dr. Majcher supported appellant's claim by finding that heart problems had an adverse impact on various internal organ functions and were an important factor contributing to the employee's death.

Dr. Diggs, Board-certified in cardiovascular disease, noted the employee's history of coronary artery disease and a large myocardial infarction in 1982, caused significant ischemic cardiomyopathy and an ejection fraction of 36 percent. He explained how the employee's heart condition was a well-known cause of liver damage called cardiac cirrhosis due to long-term passive congestion of the liver secondary to the higher pressures in the venous system being reflected back into the inferior vena cava and hepatic veins. Dr. Diggs offered a detailed physiological explanation of how the employee's heart condition contributed to his liver disease, which in turn caused his death. In the absence of any other explanation for the employee's liver disease, he concluded that cardiac cirrhosis due to the initial myocardial infarction, followed by years of congestive heart failure, was the cause of liver failure and the employee's subsequent death.

As the medical opinion evidence is thus supportive of appellant's claim and as Dr. Raisinghani did not directly address the issue of contribution, the Board finds that this case is not in posture for decision. Further, development of the medical opinion evidence is warranted. The Board will set aside OWCP's October 17, 2011 merit decision and remand the case for a supplemental report from Dr. Raisinghani, OWCP's second opinion physician. OWCP shall ask him for a well-reasoned opinion on whether the employee's acute myocardial infarction in any way contributed to his death. It shall ask Dr. Raisinghani to review the reports of Dr. Majcher and Dr. Diggs and explain whether he agrees with their view. After such further development as may become necessary, OWCP shall issue an appropriate final decision on appellant's claim for survivor benefits.

Given the Board's holding with respect to the first issue presented, the second issue, relating to OWCP's denial of a merit review, is moot.

CONCLUSION

The Board finds that this case is not in posture for decision; further development of the medical evidence is warranted.

[8] *R.M.*, Docket No. 11-1701 (issued March 19, 2012); *Arnold Gustafson*, 41 ECAB 131 (1989).

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2012 and October 17, 2011 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded for further action.

Issued: November 2, 2012
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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