

FACTUAL HISTORY

On January 25, 2013 appellant submitted a claim for compensation by widow, widower, and/or children (Form CA-5) alleging that the employee, her husband,² had passed away on January 11, 2013 due to work-related heart failure and that, therefore, she was entitled to survivor's benefits.

OWCP had accepted that on January 30, 1998 the employee, then a 45-year-old lineman, sustained injury while working on a transformer at work. The employee claim was initially approved for cervical strain and cervical disc displacement at C6 through T1. In August 1998 he underwent OWCP-authorized anterior cervical discectomy with interbody arthrodesis at C6 through T1. The medical evidence reveals that the employee suffered a myocardial infarction in August 2000. The accepted conditions were later expanded to include aggravation of preexisting coronary atherosclerosis (myocardial infarction) due to taking anti-inflammatory medication (including Naproxen) for the accepted cervical condition. The employee received compensation for temporary total disability on the periodic rolls.

In connection with her claim for survivor's benefits, appellant submitted a certificate of death, signed on January 14, 2013 by Dr. Paul Knouff, an attending Board-certified family practitioner. The certificate showed that the employee died on January 11, 2013, but the cause of death was listed as "unknown." In a portion of the certificate entitled "other conditions contributing to death" Dr. Knouff stated "coronary artery disease, chronic obstructive pulmonary disease, pneumonia."

On January 25, 2013 appellant also submitted an undated report from Providence Family Medicine East Olympia which was signed by Diana Schofield, an attending nurse practitioner,³ who provided a history that the employee suffered a crushing cervical spine injury in 1998, had cervical spinal surgery without pain relief, and was on chronic pain medication. Ms. Schofield indicated that, although the primary cause of death was unknown given there was no autopsy, the cause of death was presumed to be from coronary artery disease. She stated that the employee suffered a myocardial infarction in 2000 from chronic nonsteroidal anti-inflammatory drugs (NSAIDS) taken for his chronic pain and asserted that the coronary artery disease resulted in congestive heart failure. Ms. Schofield also indicated that the contributing causes of death were presumed to be chronic obstructive lung disease and pneumonia. In October 2012, the employee contracted community-acquired pneumonia complicated by hypotension that became life threatening and resulted in lung disease after this event.

In her report, Ms. Schofield further stated that the severity of the employee's hypotension was thought to be secondary to chronic, long-term opioid medication use. She indicated that he was subsequently treated for chronic obstructive pulmonary disease with medication therapy and that his condition improved after hospitalization. The employee was most recently treated for

² The record contains a marriage certificate showing that appellant and the employee were married on May 21, 1983 in the State of Idaho.

³ The Board notes that, in July 2013, appellant submitted a copy of this report that was cosigned by Dr. Kevin M. Haughton, an attending Board-certified family practitioner.

bronchitis on January 3, 2013 with a January 9, 2013 chest x-ray showing bilateral pneumonia. Ms. Schofield stated:

“In my opinion, [the employee’s] death was due to multiple chronic health diseases that developed after he sustained his work injury, and the subsequent treatment of the resulting chronic pain. He was never able to return to prior health status before the accident. [The employee’s] activity was severely limited, and the loss of the ability to maintain a good activity level most likely worsened the severity of his coronary heart disease. His lung function also declined, after being hospitalized in October 2012 for pneumonia. This hospitalization and complications of pneumonia were thought to have been worsened due to chronic Kadian (long acting morphine) use.

“The initial coronary heart disease diagnosis and congestive heart failure in 2000 were thought to have been caused by chronic NSAID use. Patient was taking NSAIDS due to initial injury of the cervical spine in 1998.”

On January 28, 2013 OWCP referred the case to Dr. William Stewart, a Board-certified cardiologist serving as an OWCP medical adviser, for review and an opinion regarding whether the employee’s death was caused by or was a consequence of his accepted conditions.

In a February 5, 2013 report, Dr. Stewart discussed the medical treatment for the employee’s January 30, 1998 cervical injury which included taking NSAIDS and narcotic analgesics on a chronic basis. He noted that the employee sustained a myocardial infarction in 2000 and underwent coronary artery stenting in 2002. Dr. Stewart indicated that obvious contributing factors to the myocardial infarction included cigarette smoking, hypertension, and hyperlipidemia. He stated that records revealed that the employee continued to smoke and was noncompliant with his cardiac medications and that, in October 2011, he developed pneumonia complicated by hypotension. Dr. Stewart noted that in November 2011 Dr. Craig J. Wehrli, an attending Board-certified cardiologist, reported the diagnoses of atherosclerotic heart disease, left bundle branch block, hyperlipidemia, cardiomyopathy, chronic obstructive pulmonary disease, and congestive heart failure and that the studies done at that time demonstrated the coronary arteries to be stable, with no intervention indicated, and with a left ventricular ejection fraction of 55 percent.⁴ He indicated that, prior to the employee’s death at home on January 11, 2013, he had developed pneumonia that was life threatening and that on January 9, 2013 he was again shown to have bilateral pneumonia. Dr. Stewart noted that the death certificate indicated the cause of death as unknown. He addressed the report of Ms. Schofield and posited that there was no objective evidence that the coronary artery disease contributed to the employee’s death based on Dr. Wehrli’s direct visualization of the coronary arteries in November 2011 and his finding that the condition was stable and nonlife threatening. Dr. Stewart opined that the most rational conclusion was that the employee’s death was due to chronic obstructive pulmonary disease and bilateral pneumonia as he had an episode of pneumonia and respiratory failure two months prior and had just started treatment for an apparently new episode of bilateral

⁴ The record contains copies of November 3, 14, and 17, 2011 evaluations conducted by Dr. Wehrli.

pneumonia two days before his death. He stated that there was no evidence that the employee's death was related to the use of NSAIDS or the use of narcotic analgesics.

By decision dated February 25, 2013, OWCP denied appellant's claim for survivor's benefits because she did not submit sufficient medical evidence to show that a work-related condition contributed to the employee's death on January 11, 2013. It indicated that the report of Ms. Schofield did not constitute medical evidence and that the February 5, 2013 report of Dr. Stewart showed that the employee's death was not related to the accepted injury-related conditions.

Appellant submitted a copy of Ms. Schofield's undated report, originally received on January 25, 2013, which was cosigned by Dr. Haughton.

Appellant requested a telephonic hearing with an OWCP hearing representative. During the hearing held on July 16, 2013, counsel argued that the report cosigned by Dr. Haughton supported appellant's claim. He argued that the certificate of death provided *prima facie* evidence that one of the causes of the employee's death was the coronary artery disease. Counsel stated that there had been no ruling that the accepted coronary condition had gone back to its preinjury status or that it failed to continue to exist. He argued that the hypotension which complicated the employee's pneumonia was also thought to be secondary to chronic opioid medication for his accepted cervical injury. Counsel claimed that since no autopsy was performed OWCP had to accept the "presumed conditions" as being the cause of death.

In a September 19, 2013 decision, OWCP hearing representative affirmed OWCP's February 25, 2013 decision denying appellant's claim for survivor's benefits. She indicated that the report that was initially signed by Ms. Schofield constituted medical evidence after it was cosigned by Dr. Haughton, but found that Dr. Haughton did not provide adequate medical rationale in support of the opinion that a work-related condition contributed to the employee's death on January 11, 2013.

LEGAL PRECEDENT

Appellant has the burden of proving by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his employment.⁵ This burden includes the necessity of furnishing rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship.⁶ An award of compensation may not be based on surmise, conjecture, or speculation.⁷ The mere showing that an employee was receiving compensation at the time of his death does not establish that his death was causally related to conditions resulting from employment.⁸ The report of nonphysicians

⁵ *Gertrude T. Zakrajsek (Frank S. Zakrajsek)*, 47 ECAB 770 (1996); *Carolyn P. Spiewak (Paul Spiewak)*, 40 ECAB 552 (1989); *Lorraine E. Lambert (Arthur R. Lambert)*, 33 ECAB 1111 (1982).

⁶ *Martha A. Whitson (Joe E. Whitson)*, 43 ECAB 1176 (1992).

⁷ *Myrl Nix (Earl Nix)*, 15 ECAB 125 (1963).

⁸ *Leonora A. Buco (Guido Buco)*, 36 ECAB 588 (1985).

under FECA, such as nurses and physician's assistants, do not constitute probative medical evidence.⁹

Section 8123(a) of FECA 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."¹⁰ When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.¹¹

ANALYSIS

OWCP accepted that on January 30, 1998 the employee sustained injury while working on a transformer at work. The employee's claim was initially approved for cervical strain and cervical disc displacement at C6 through T1 and he later underwent OWCP-authorized anterior cervical discectomy with interbody arthrodesis at C6 through T1. He suffered a myocardial infarction in August 2000 and the accepted conditions were later expanded to include aggravation of preexisting coronary atherosclerosis (myocardial infarction) due to taking anti-inflammatory medication (including Naproxen) for the accepted cervical condition.

The employee died on January 11, 2013. On January 25, 2013 appellant (the employee's widow) submitted a CA-5 form alleging that the employee's death on January 11, 2013 was due, at least in part, to work-related heart failure and that, therefore, she was entitled to survivor's benefits.

The Board finds that there is a conflict in the medical evidence between Dr. Haughton and Dr. Knouff, attending Board-certified family practitioners, and Dr. Stewart, a Board-certified cardiologist serving as an OWCP medical adviser, regarding whether a work-related condition contributed to the employee's death on January 11, 2013.

The Board notes that an undated medical report which was initially submitted in a version signed only by Ms. Schofield, an attending nurse practitioner, was later submitted in a version which was cosigned by Dr. Haughton. Therefore, this report does in fact constitute medical evidence.¹² In this report, Dr. Haughton provided an opinion that a work-related medical condition contributed to the employee's death on January 11, 2013. He indicated that, although the primary cause of death was unknown given there was no autopsy, the cause of death was presumed to be from coronary artery disease. Dr. Haughton stated that the employee suffered a myocardial infarction in 2000 from chronic nonsteroidal anti-inflammatory drugs taken for his chronic pain and asserted that the coronary artery disease resulted in congestive heart failure. He

⁹ *L.L.*, Docket No. 13-829 (issued August 20, 2013); *Bertha L. Arnold*, 38 ECAB 282, 285 (1986); 5 U.S.C. § 8101(2).

¹⁰ 5 U.S.C. § 8123(a).

¹¹ *William C. Bush*, 40 ECAB 1064, 1075 (1989).

¹² *See supra* note 9.

indicated that the severity of the employee's hypotension was thought to be secondary to chronic, long-term opioid medication use and noted, "In my opinion, [the employee's] death was due to multiple chronic health diseases that developed after he sustained his work injury, and the subsequent treatment of the resulting chronic pain...." Moreover, the record contains a certificate of death, signed on January 14, 2013 by Dr. Knouff, an attending Board-certified family practitioner. Although the cause of death on January 11, 2013 was listed as "unknown," Dr. Knouff indicated a portion of the certificate entitled "other conditions contributing to death" that "coronary artery disease" was one of the contributing causes to death. Aggravation of preexisting coronary atherosclerosis, an underlying condition to coronary artery disease, was an accepted condition.

In contrast, Dr. Stewart reviewed the medical record and provided an opinion that a work-related condition did not contribute to the employee's death on January 11, 2013. In a February 5, 2013 report, he found that there was no objective evidence that the employee's death was due to coronary artery disease or the use of NSAIDs or narcotic analgesics. Dr. Stewart indicated that, prior to the employee's death at home on January 11, 2013, he had developed pneumonia that was life threatening and that on January 9, 2013 he was again shown to have bilateral pneumonia. He posited that there was no objective evidence that the coronary artery disease contributed to the employee's death based on an attending cardiologist's direct visualization of the coronary arteries in November 2011 and his finding that the condition was stable and nonlife threatening. Dr. Stewart asserted that the most rational conclusion was that the employee's death was due to chronic obstructive pulmonary disease and bilateral pneumonia as he had an episode of pneumonia and respiratory failure two months prior and had just started treatment for an apparently new episode of bilateral pneumonia two days before his death. He felt that there was no evidence that the employee's death was related to the use of NSAIDs or the use of narcotic analgesics.

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence between the attending physicians, Dr. Haughton and Dr. Knouff, and OWCP physician, Dr. Stewart, regarding whether a work-related condition contributed to the employee's death on January 11, 2013. On remand OWCP should refer the case file and the statement of accepted facts to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After carrying out this development, OWCP should issue an appropriate decision regarding appellant's claim for survivor's benefits.

CONCLUSION

The Board finds the case is not in posture for decision regarding whether appellant met her burden of proof to establish that she is entitled to survivor's benefits. There is a conflict in the medical opinion evidence requiring further development of this matter.

ORDER

IT IS HEREBY ORDERED THAT the September 19, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: March 27, 2015
Washington, DC

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

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

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