U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SAMMY W. SHAW and DEPARTMENT OF AGRICULTURE, CARSON NATIONAL FOREST, Taos, N.M.

Docket No. 96-963; Submitted on the Record;
Issued February 2, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that his ventrical tachycardia and pacemaker implantation on March 6, 1995 were causally related to his accepted May 23, 1970 myocardial infarction.

On May 23, 1970 appellant, a 42-year-old firefighter, sustained a myocardial infarction while climbing a steep mountain on his way to fight a fire. Appellant filed a Form CA-2 claim for benefits based on occupational disease on June 30, 1970, which the Office of Workers' Compensation Programs accepted for an inferior myocardial infarction and hypopituitarism. Appellant received total disability compensation.

In a report dated January 24, 1984, Dr. Paul T. Cochran, Board-certified in internal medicine and a specialist in cardiology, stated that he last examined appellant on December 6, 1983, at which time his diagnosis was coronary heart disease, status post inferior wall myocardial infarction 1970, complicated by sustained and recurrent ventricular tachyarrthmias. Dr. Cochran, appellant's treating physician, stated that appellant's clinical course was one of recurrent complaints of irregular heartbeat which had been documented to be related to frequent ventricular premature contractions. He advised that appellant clinically had not been able to carry out any meaningful and regular occupational activities for the past several years and indicated that under periods of emotional stress he seemed to have much more frequent ventricular ectopy. Dr. Cochran stated that appellant had experienced one documented episode of sustained ventricular tachycardia which required cardioversion.

Appellant underwent coronary bypass surgery on August 21, 1985.

In March 1995, appellant requested authorization from the Office for cardiac catheterization. In a memorandum dated March 3, 1995, an Office medical adviser indicated that the requested cardiac catheterization was not causally related to appellant's accepted condition of inferior myocardial infarction, which he characterized as an "isolated event from the distant

past." Rather, the Office medical adviser stated the catheterization was necessary for his underlying ventricular tachycardia and underlying atherosclerotic coronary artery disease and its expected progression.

On March 3, 1995 appellant underwent cardiac catheterization for treatment of a ventricular arrhythmia and he was scheduled for placement of a automatic implantable cardioverter/defibillator which was performed on March 6, 1995.

In a memorandum dated April 3, 1995, the medical adviser noted that the accepted myocardial infarction occurred some 25 years prior to appellant's pacemaker implant. The medical adviser opined that although the initial infarction was followed by ventricular arrythmias, the present deterioration was in all probability the end product of the slow progression of his underlying coronary artery disease, rather than the 1970 myocardial event. The medical adviser therefore concluded that any treatment of appellant's heart condition "at this late date" would not be employment related.

In a decision dated April 20, 1995, the Office denied appellant's claim for payment of the surgical procedures performed in March 1995; *i.e.*, cardiac catheterization and implantation of an automatic implantable cardiac defibrillator. The Office found that appellant's current treatment was for his underlying arteriosclerotic heart disease and was not related to his 1970 employment-related myocardial infarction.

By letter dated July 11, 1995, appellant's attorney requested reconsideration of the Office's April 20, 1995 decision. Appellant's attorney contended that the Office improperly denied appellant's claim based on the Office medical adviser's opinion. Appellant's attorney also attached an updated medical report from Dr. Cochran, dated June 15, 1995. Dr. Cochran stated:

> "[Appellant's] history of coronary heart disease is quite extensive. He initially sustained a myocardial infarction in 1970 which was large, inferior in location and complicated at that time by sustained ventricular tachycardia. Through the years he has had recurrent episodes of ventricular tachycardia, some requiring hospitalizations, others not. One of these is well documented and occurred in 1977. Most recently, he [was admitted to the hospital] on February 28, 1995, in shock with ventricular tachycardia requiring direct current counter shock in the emergency room for the restitution of heart rhythm.
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> "I believe [the OMA] addresses the wrong question when he responds to the request for cardiac catheterization, 'for the accepted condition of inferior wall myocardial infarction or is it necessary for his underlying ventricular tachycardia.…' [The OMA] does not recognize that the purpose of the cardiac catheterization in this situation; *i.e.*, recurrent, sustained ventricular tachycardia in a patient with a long history of ventricular tachycardia. The catheterization was undertaken to determine whether or not there had been progression of coronary artery disease that might be addressed primarily in treating his ventricular tachycardia. The cardiac catheterization did not demonstrate any site of reversible ischemia that might be approached by further revascularization in the

> treatment of his ventricular tachycardia. The cardiac catheterization, therefore, indicated we have a patient who has failed medical therapy in the treatment of his recurrent ventricular tachycardia and today the only alternative to the management of this life-threatening condition is insertion of a pacemaker cardioverter defibrillator. This was performed on March 6, 1995.
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> "Regarding [the OMA's] letter of March 3, 1995, I wish to inform him that the cardiac catheterization did not indicate progression of disease that would warrant further revascularization surgery. Therefore, in this particularly complex patient with cardiac disease, cardiac cathaterization was done as part of his work-up to determine the management of the problem of recurrent ventricular tachycardia. It is, in my judgement, only logical to accept that this patient's problem of recurrent ventricular tachycardia, which has been well documented since 1970, is the direct result of the large inferior wall myocardial infarction he suffered at that time."

In response to appellant's request, the Office prepared a statement of accepted facts and referred the case file back to the Office medical adviser. In a September 28, 1995 report, the medical adviser, when asked whether there was a medical connection between the ventricular tachycardia in 1977 and the 1970 myocardial infarction, stated that the records indicated a number of cardiac arrhythmias during the acute infarction, which were not mentioned again until after the 1977 episode. The medical adviser then opined that the underlying cause of the myocardial infarction and the arrhythmias had to be assumed to be due to atherosclerotic coronary artery disease. He further opined that the 1977 ventricular tachycardia was related to appellant's pituitary insufficiency during that episode. When asked whether appellant's 1985 coronary bypass surgery was warranted for treatment of the 1970 myocardial infarction, or whether it was due to advancement of arteriosclerotic heart disease, the medical adviser opined that the coronary artery bypass surgery was performed primarily because of a left main coronary artery obstruction of 70 percent and "ischemic sounding pain" [chest pain]. The Office medical adviser concluded that appellant's surgery was due to the advancement of his arteriosclerotic heart disease. The medical adviser also agreed that the implantation of a pacemaker was warranted for treatment of ventricular tachycardia. He stated:

> "In my opinion, the recent (1995) arrhythmia is the result of the natural progression of [appellant's] underlying heart disease rather than a direct result of the remote myocardial infarction of 1970. It may be stated categorically that any person surviving a myocardial infarction is very likely to eventually succumb to the advancement of the coronary artery atherosclerotic process some time in the future and that the terminal events will include ventricular arrhythmias. Although this claimant had a ventricular tachycardia in 1977, which may or may not have been a directly caused by the 1970 [myocardial infarction], there has been obvious evidence of the expected progression of the atherosclerotic process. The first mention of a 1977 [catheterizaion] result reports single artery disease with 100 percent [right coronary artery] occlusion. By 1985, (prior to the bypass surgery) there was now a 70 percent occlusion of the left main coronary artery. A [catheterizaion] report of 1995 now shows a totally occluded [right coronary artery] proximally to the [the left main coronary artery] graft and a distal 30

> percent narrowing. The diagnosis at that time, (Dr. Cochran), includes ischemic cardiomyopathy and multi vessel [coronary artery disease]. These were not present in the records prior to 1977 and document the typical, expected, progression of this disorder. At the same time, there is evidence, progression of this disorder. At the same time, there is evidence that [appellant] was suffering from a generalized atherosclerotic disease as manifested by the 1980 diagnosis of 'new onset claudication' with absent right pedal pulses."

The medical adviser concluded that the advancement of this atherosclerotic process was, in all probability, the direct cause of appellant's present disorder, rather than the remote myocardial infarction of 25 years ago.

By decision dated October 2, 1995, the Office modified its previous decision. The Office noted that it had accepted pituitary damage secondary to poor pituitary profusion during the 1977 episode of ventricular tachycardia on October 1, 1977, which was a consequence of the 1970 employment-related myocardial infarction. The Office stated, however, that having accepted intermittent arrhythmias from 1970 to 1977 and an acute episode of tachycardia in 1977, it could not infer that all subsequent arrhythmias were necessarily a direct result of the 1970 myocardial infarction. The Office stated that appellant had underlying cardiac disease, which by nature was a progressive disease and that therefore deterioration over time was expected. The Office found that appellant's episode of ventricular tachycardia requiring electric conversion on February 28, 1995 was not related to the 1977 injury.

By letter dated November 28, 1995, appellant's attorney requested reconsideration of the Office's October 5, 1995 decision. Accompanying the request was a November 21, 1995 report from Dr. Cochran, who stated that the Office medical adviser apparently did not recognize that the ventricular tacharrhythmias was a late complication of the 1970 myocardial infarction. Dr. Cochran stated that appellant's initial episode of ventricular tachycardia occurred in 1970, that he had ventricular tachycardia in 1977 and that this problem was controllable with medical therapy until 1995, when despite medical therapy he again sustained ventricular tachycardia.

By decision dated January 2, 1996, the Office denied appellant's application for review on the ground that it neither raised substantive legal questions nor included new and relevant evidence such that it was sufficient to require the Office to review its prior decision.

The Board finds that the case is not in posture for a decision due to a conflict in medical opinion.

In the present case, there is a disagreement between the Office medical adviser and Dr. Cochran, as to whether appellant's February 28 to March 3, 1995 ventricular tachycardia and March 6, 1995 pacemaker implant were causally related to employment factors; *i.e.*, the 1970 myocardial infarction. Dr. Cochran stated in his June 15, 1995 report that the cardiac catheterization had been performed on March 3, 1995 because appellant had suffered recurrent, sustained ventricular tachycardia and indicated that because appellant had failed medical therapy in the treatment of his recurrent ventricular tachycardia, the only alternative to the management of this life-threatening condition was insertion of a pacemaker, which was performed on March 6, 1995. Dr. Cochran specifically rejected the medical adviser's opinion that the cardiac

catheterization did not indicate progression of disease that would warrant further revascularization surgery and concluded that it was only logical to accept that appellant's problem of recurrent ventricular tachycardia, which had been well documented since 1970, was the direct result of the large inferior wall myocardial infarction he suffered in 1970.

In contrast to Dr. Cochran's opinion, the Office medical adviser opined that appellant's March 1995 arrhythmia was the result of the natural progression of his underlying heart disease rather than a direct result of the "remote" 1970 myocardial infarction. He indicated it was likely that that anyone surviving a myocardial infarction would eventually succumb to the advancement of the coronary artery atherosclerotic process and that the terminal events would include ventricular arrhythmias. The medical adviser added that while the ventricular tachycardia appellant sustained in 1977 may or may not have been caused by the 1970 myocardial infarction, there had been obvious signs of the expected progression of the atherosclerotic process. These signs included greater narrowing and occlusion of the coronary arteries, ischemic cardiomyopathy and multi vessel coronary artery disease, all of which were not present in the records prior to 1977 and reflected the typical, expected, progression of this disorder. The medical adviser further stated that there was evidence that appellant was suffering from a generalized atherosclerotic disease as manifested by the 1980 diagnosis of new onset claudication with absent right pedal pulses. He concluded that the advancement of this atherosclerotic process was, in all probability, the direct cause of appellant's present disorder, rather than the remote myocardial infarction of 25 years ago.

Section 8123(a) of the Federal Employees' Compensation Act requires the Office to appoint a third or "referee" physician, when a conflict in medical opinion arises between a claimant's physician and a physician acting on behalf of the government.[1] In order to resolve the conflict of medical opinion, the Office should refer appellant, the case record and a statement of accepted facts, to an appropriate impartial medical specialist or specialists for a reasoned opinion as to whether appellant's heart condition was sustained or aggravated by employment factors. After such development as it deems necessary, the Office shall issue a *de novo* decision.

[1] Section 8123(a) of the Federal Employees' Compensation Act provides in pertinent part, "(i)f there is a 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." *See Dallas E. Mopps*, 44 ECAB 454 (1993).

The Office's decision of October 2, 1995 is therefore set aside and the case is remanded to the Office for further action consistent with this decision of the Board.

Dated, Washington, D.C.
February 2, 1999

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member