**United States Department of Labor**
**Employees' Compensation Appeals Board**

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| **P.P., Appellant**<br><br>**and**<br><br>**DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Richmond, VA, Employer** | ) | **Docket No. 17-0023**<br>**Issued: June 4, 2018** |

*Appearances:*
*Stephanie N. Leet, Esq.,* for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

# DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

## ***JURISDICTION***

On October 11, 2016 appellant, through counsel, filed a timely appeal from an April 13, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

## ***ISSUES***

The issues are: (1) whether OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective May 6, 2014, as he no longer suffered residuals or disability due to his work-related injury; and (2) whether appellant has established that he continued to suffer residuals or disability due to his work-related injury after May 6, 2014.

## ***FACTUAL HISTORY***

On February 13, 1994 appellant, then a 46-year-old revenue officer, filed an occupational disease claim (Form CA-2) alleging that he suffered from heart problems as a result of extreme stress from his employment. He first became aware of his condition on April 19, 1990 and realized it resulted from his employment on January 2, 1994. Appellant did not stop work.

Appellant received medical treatment from Dr. Stephen A. Malone, Board-certified in internal medicine and cardiovascular disease. In a March 7, 1994 report, Dr. Malone indicated that appellant had been under his care since July 17, 1992 for complex coronary artery disease. He noted that appellant had a history of hypercholesterolemia and past myocardial infarctions in 1990 and 1992. Dr. Malone discussed the various medical treatments appellant received, including several heart surgeries. He diagnosed severe multivessel coronary disease. Dr. Malone opined that the mental stress placed on appellant by his occupation was in part responsible for his significant coronary disease. He noted that appellant would be best served by a much less stressful lifestyle and occupation. Dr. Malone reported that appellant may require coronary bypass surgery in the not too distant future.

On July 21, 1994 appellant stopped work and underwent coronary bypass surgery. He returned to work in September 1994. On January 1, 1995 appellant stopped work again.

OWCP accepted appellant's claim for aggravation of coronary heart disease. It paid wage-loss compensation on the periodic rolls, effective March 27, 1995.

On May 2, 1995 OWCP referred appellant for vocational rehabilitation in order to determine appellant's work restrictions and assist him in his return to work. On August 19, 1998 a vocational rehabilitation counselor determined that due to appellant's medical restrictions it was not feasible for rehabilitation to continue or for him to return to work. Appellant's rehabilitation case was closed effective August 18, 1998.

Appellant continued to receive medical treatment from Dr. Malone and underwent hospitalizations for his coronary heart condition. On November 29, 2004 appellant underwent left heart catheterization with left ventriculography coronary and graft arteriography. He underwent another left heart catheterization on August 4, 2005.

On June 8, 2007 OWCP again referred appellant for vocational rehabilitation. On August 1, 2008 an OWCP vocational rehabilitation counselor closed appellant's rehabilitation case because further medical development was necessary to determine appellant's work restrictions.

Dr. Malone submitted periodic medical reports. He indicated that appellant underwent a left heart catheterization and was hospitalized in January 2009.

In an October 21, 2013 examination record, Dr. Malone indicated that he had been treating appellant for hyperlipidemia and coronary artery disease. He noted that appellant's treadmill test in February was reassuring and that appellant had been free of chest discomfort and dyspnea. Dr. Malone reviewed appellant's history and provided physical examination findings. He recommended that appellant continue present medications and undergo a treadmill test in three months to reevaluate his coronary artery disease.

On February 20, 2014 OWCP referred appellant, along with the statement of accepted facts (SOAF) dated September 2008, and the case record, to Dr. Daniel Gottlieb, Board-certified in internal medicine, interventional cardiology, and cardiovascular disease, for a second opinion examination to determine whether appellant continued to suffer residuals and remained disabled from work due to his accepted aggravation of preexisting coronary artery disease.

In a March 18, 2014 report, Dr. Gottlieb indicated that he reviewed the September 2008 SOAF[3] and discussed appellant's extensive history of coronary artery disease. He noted that appellant had heart attacks in 1990, 1992, and 1994 and had been hospitalized several times due to his coronary problems. Dr. Gottlieb reviewed appellant's medical records and discussed that a recent stress test, electrocardiogram, and blood work were normal. He related that appellant's current symptoms included fatigue. Upon physical examination, Dr. Gottlieb reported no murmurs, no peripheral edema, no jugular vein distention, and no bruits. He pointed out that appellant's recent treadmill tests had shown excellent exercise capacity. Dr. Gottlieb further noted that objective evidence showed no evidence for significant ischemia or congestive heart failure. He opined that at this time appellant was doing well from a cardiac point of view and was asymptomatic. Dr. Gottlieb diagnosed hyperlipidemia, negative heart failure, status post myocardial infarction, status post coronary artery bypass graft, and status post stents.

Dr. Gottlieb reported that appellant had a long history of hyperlipidemia and a strong family of history of heart disease with a very extensive cardiovascular history, although fairly minimal records were available to him. He opined that any aggravation of appellant's preexisting coronary disease had resolved. Dr. Gottlieb reported:

> "The aggravation of the examinee's coronary disease led to an acute coronary syndrome which led to the uncovering of examinee's previously unknown coronary disease and led to examinee's revascularization. [Appellant] has been revascularized multiple times; the last of which was in 2004. In the past ten years, he has required no cardiac intervention. [Appellant's] cardiac condition is stable."

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[3] This SOAF related that OWCP had accepted appellant's claim for aggravation of his preexisting coronary artery disease. It also related that appellant had a myocardial infarction in April 1990. During his hospitalization for this infarction appellant also had a blood clot, which was dissolved. He had a second myocardial infarction in July 1992. Appellant thereafter underwent angioplasty. His third myocardial infarction occurred in January 1994, he again underwent angioplasty and had a stent placed. Appellant underwent a double by-pass surgery on July 21, 1994. He underwent left heart catherization with left ventriculography and coronary graft arteriography on November 21, 1995. On January 3, 2002 appellant underwent stent placement in the mid-circumflex. Another left cardiac catherization with left ventriculography, coronary arteriography and graft arteriography was performed on April 2, 2002. On June 11, 2003 and November 29, 2004 appellant underwent left heart catherization with left ventriculography, coronary artery graft arteriography and cutting balloon dilation, with drug-eluting stent placement.

Dr. Gottlieb indicated that appellant's accepted aggravation of coronary artery disease resolved at the time of appellant's bypass surgery in 1994. He explained that there was an eight-year gap during which time appellant required no further intervention. Dr. Gottlieb concluded that appellant did not have any physical limitations from a cardiac point of view and was capable of performing his date-of-injury job without limitations. In a work capacity evaluation form, he indicated that appellant was capable of returning to work without limitations.

On April 1, 2014 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits because the medical evidence of record established that appellant no longer had any residuals of his accepted employment injury and was able to return to work. It found that the weight of medical evidence rested with the March 18, 2014 second opinion report of Dr. Gottlieb, who found that appellant's work-related heart condition had ceased and that he was no longer disabled as a result of his employment injury. Appellant was afforded 30 days to submit additional evidence or argument, in writing, if he disagreed with the proposed termination.

In an April 4, 2014 letter, Dr. Malone related that appellant had been under his care for chronic ischemic heart disease since 1990 shortly after his first myocardial infarction. He noted that appellant subsequently underwent a three-vessel coronary bypass surgery and multiple coronary stent placements. Dr. Malone reported that appellant's right coronary artery was chronically occluded and that only part of the vessel was grafted. He indicated that he last examined appellant on October 21, 2013 and observed that appellant's chest pains and angina had been controlled due to medications and life style changes which minimized stress. Dr. Malone reported that appellant had a history of recurrent chest pain when subjected to mental or emotional stress, particularly in the work setting. He noted that an attempt to reenter the work force in January 2009 led to chest pains and required repeated heart catheterizations. Dr. Malone opined that appellant was not employable at the age of 66 with his history of recurrent chest pain in the work environment.

By decision dated May 5, 2014, OWCP finalized the termination of appellant's wage-loss compensation and medical benefits. It noted that Dr. Malone's letter was insufficient to alter the proposed termination of appellant's entitlement to wage-loss compensation and medical benefits because he did not attribute appellant's condition to appellant's employment. OWCP determined that the weight of medical evidence rested with Dr. Gottlieb's March 18, 2014 second opinion report.

Appellant requested a telephone hearing before an OWCP hearing representative by form dated May 12, 2014, received by OWCP on May 15, 2014. A hearing was held on December 3, 2014. Appellant described the various medical treatments he received for his cardiac artery condition, including procedures and surgeries. He indicated that Dr. Malone, his treating physician, wanted him to avoid mental or emotional stress, particularly in the work setting because appellant still had an occluded right coronary artery. Appellant noted that he still had coronary heart disease and experienced episodes, which felt like an elephant standing in the middle of his chest. Counsel reviewed Dr. Malone's April 4, 2014 letter, in which he opined that appellant was not employable due to his history of recurrent chest pains in the work environment and his age. She asserted that the previous claims examiner was not aware of appellant's participation in

vocational rehabilitation in 2007 or appellant's attempt to return to work in 2009.[4] Counsel contended that she did not think that Dr. Gottlieb was aware of appellant's entire history as it was not included in the SOAF. She noted that Dr. Gottlieb indicated that appellant had no cardiac problems since 2004 even though appellant had several recatheterizations. Counsel also reported that Dr. Gottlieb admitted that he had "minimal records to rely on." She argued that Dr. Gottlieb's medical opinion was not based on a complete background and as such the report should therefore be discounted or, in the alternative, appellant's case should be referred to an impartial medical examiner due to a conflict in medical opinion.

In a letter dated December 15, 2014, counsel asserted that OWCP did not meet its burden to justify termination of appellant's wage-loss compensation and medical benefits. She asserted that because Dr. Gottlieb was provided with a SOAF dated September 10, 2008 his opinion was based on an incomplete history and should not carry any weight. Counsel noted that the SOAF did not include several medical procedures that appellant underwent from 2001 to 2014. She also noted that Dr. Gottlieb noted that he reviewed "fairly minimal records." Counsel further asserted that OWCP erroneously determined that Dr. Malone's April 4, 2014 letter was based on an inaccurate history because Dr. Malone mentioned a 2009 employment incident. She contended that because the weight of evidence failed to establish that appellant no longer suffered residuals of his accepted work-related condition and remained disabled, OWCP should not terminate his compensation benefits.

By decision dated February 3, 2015, an OWCP hearing representative affirmed the May 5, 2014 termination decision. He determined that OWCP properly accorded the weight of medical evidence to Dr. Gottlieb, the second opinion examiner who based his opinion on an accurate history of injury and examination findings, and met its burden to justify termination of appellant's wage-loss compensation and medical benefits. The hearing representative reported that Dr. Gottlieb relied on a proper SOAF, which contained an accurate description of appellant's employment factors and his accepted condition. He noted that, although Dr. Malone opined that appellant still suffered from coronary artery disease, he did not differentiate whether appellant's current symptoms were related to his preexisting heart condition or the work-related aggravation of coronary artery disease.

On January 26, 2016 OWCP received appellant's request, through counsel, for reconsideration. In a letter dated January 18, 2016, counsel asserted that appellant still suffered residuals of his accepted condition that prevented him from working. She contended that Dr. Gottlieb's second opinion report was based on limited record review and an incomplete SOAF, and accordingly, should not carry any weight. Counsel noted that the 2008 SOAF that Dr. Gottlieb relied on failed to mention that appellant had two stents in 2001 and heart catheterizations in 2005, 2009, and 2014. She further asserted that appellant's condition had worsened since the March 18, 2014 second opinion report. Counsel indicated that a new medical report by Dr. MacGregor showed that appellant began suffering premature ventricular contractions (PVC). She contended that Dr. Malone, who had treated appellant since 1990, was the only physician who had a full and complete history of appellant's accepted condition. Counsel alleged that, if Dr. Gottlieb's report

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[4] The record does not contain evidence that appellant returned to work in 2009. On January 12, 2010 appellant signed a Form EN1032 in which he reported that he had not worked during the previous 15 months.

was not completely disregarded, the claim should be referred to an impartial medical examiner due to a conflict in medical opinion regarding the nature of appellant's work-related injury.

On January 26, 2016 OWCP received an April 23, 2015 letter from Dr. Malone. Dr. Malone noted that he had treated appellant since 1994. He indicated that he had reviewed appellant's medical records and provided a brief history of the progression of appellant's coronary artery disease. Dr. Malone reported that since appellant stopped work, his angina had dramatically improved and his coronary artery disease had stabilized based on treadmill testing and coronary arteriography. He related that appellant's heart condition stabilized only after removal from his previous stressful work situation. Dr. Malone noted that appellant's present diagnosis was "coronary artery disease with previous coronary artery bypass surgery presently 'angina-free." He opined that appellant's anginas would return and progress if appellant returned to a stressful work situation. Dr. Malone explained that his opinion on the rapid progression of appellant's coronary artery disease on cardiac catheterizations from 1990 to 1994 while working at the employing establishment and the lack of progression of appellant's coronary artery disease on heart catheterizations the last 10 years while not working. Appellant also resubmitted Dr. Malone's April 4, 2014 letter and various progress notes dated September 10 to December 4, 2015.

Appellant submitted a letter dated December 16, 2015 by Dr. John F. MacGregor, Board-certified in clinical cardiac electrophysiology. He noted that appellant was initially referred to him in October 2015 by Dr. Malone, and he observed that appellant's coronary anatomy was stable. Dr. MacGregor indicated that subsequent to his consultation on October 21, 2015 appellant had developed increasingly problematic shortness of breath, felt more fatigued, had abnormal PVCs on electrocardiogram (EKG) tracings, and suffered a drop in his ejection fraction to 43 percent in a follow-up stress test. He reported that stressors such as stimulants, exercise, and other physical or psychological stress (including that imposed by certain working conditions) could definitely exacerbate high blood pressure, ischemic heart disease, and arrhythmias, such as what appellant was now suffering from. Dr. MacGregor opined that because he was not acquainted with the specifics of appellant's work conditions, he could not elaborate on how appellant's aggravation while working had caused a permanent aggravation of his coronary artery condition. He opined that appellant's chronic condition (ischemic heart disease) had been permanently aggravated. Dr. MacGregor noted that appellant's ventricular function was suffering and appellant had high frequency PVCs. He included blood test laboratory results and diagnostic test results dated September 16 and October 15, 2015.

By decision dated April 13, 2016, OWCP denied modification of its February 3, 2015 decision. It found that the weight of medical evidence rested with Dr. Gottlieb, the second opinion examiner, who opined in a March 18, 2014 report that appellant's accepted aggravation of coronary artery disease condition had ceased. OWCP determined that the medical evidence submitted with appellant's reconsideration request did not provide a reasoned medical opinion explaining how appellant still experienced residuals of his accepted employment injury.

## ***LEGAL PRECEDENT***

According to FECA, once OWCP accepts a claim and pays compensation, it has the burden of justifying termination or modification of an employee's benefits.[5] OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[6] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[7]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.[8] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[9]

When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which provides that, 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 and resolve the conflict of medical evidence.[10] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.

## ***ANALYSIS***

OWCP accepted appellant's claim for aggravation of coronary artery disease. Appellant stopped work in January 1995 and was placed on the periodic rolls. In a March 18, 2014, report, Dr. Gottlieb concluded that there were no objective medical findings to support that appellant's work-related aggravation of coronary artery disease was currently active. OWCP determined that Dr. Gottlieb's opinion constituted the weight of the evidence and thereafter terminated appellant's entitlement to wage-loss compensation and medical benefits.

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits because a conflict in the medical opinion evidence

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[5] *S.F.,* 59 ECAB 642 (2008); *Kelly Y. Simpson,* 57 ECAB 197 (2005); *Paul L. Stewart,* 54 ECAB 824 (2003).

[6] *Jason C. Armstrong,* 40 ECAB 907 (1989); *Charles E. Minnis,* 40 ECAB 708 (1989); *Vivien L. Minor,* 37 ECAB 541 (1986).

[7] *See Del K. Rykert,* 40 ECAB 284, 295-96 (1988).

[8] *T.P.,* 58 ECAB 524 (2007); *Kathryn E. Demarsh,* 56 ECAB 677 (2005); *A.P.,* Docket No. 08-1822 (issued August 5, 2009).

[9] *James F. Weikel,* 54 ECAB 660 (2003); *Pamela K. Guesford,* 53 ECAB 727 (2002); *A.P.,* Docket No. 08-1822 (issued August 5, 2009).

[10] *P.C.*, Docket No. 16-1714 (issued October 18, 2017).

had been created between Dr. Malone and Dr. Gottlieb, regarding whether appellant's accepted employment injury had resolved.

In a March 18, 2014 report, Dr. Gottlieb indicated that he reviewed the September 2008 SOAF dated and discussed appellant's history of coronary artery disease. He noted that appellant had heart attacks in 1990, 1992, and 1994 and had been hospitalized several times due to his coronary problems. Dr. Gottlieb reviewed appellant's medical records and discussed that a recent stress test, electrocardiogram, and blood work were normal. He related that appellant's current symptoms included fatigue. Upon physical examination, Dr. Gottlieb reported no murmurs, no peripheral edema, no jugular vein distention, and no bruits. He noted that appellant's recent treadmill tests had shown an excellent exercise capacity. Dr. Gottlieb further noted that objective evidence showed no evidence for significant ischemia or congestive heart failure. He opined that, appellant was doing well from a cardiac point of view and was asymptomatic. Dr. Gottlieb diagnosed hyperlipidemia, negative heart failure, status post myocardial infarction, status post coronary artery bypass graft, and status post stents. He reported that appellant had a long history of hyperlipidemia and a strong family of history of heart disease with a very extensive cardiovascular history, although fairly minimal records were available to him. Dr. Gottlieb opined that any aggravation of appellant's preexisting coronary disease had resolved. In a work capacity evaluation form, he indicated that appellant was capable of returning to work without limitations.

In contradistinction, appellant's treating physician, Dr. Malone opined that the mental stress placed on appellant by his occupation was in part responsible for his significant coronary disease. He noted that appellant underwent three-vessel coronary bypass surgery and multiple coronary stent placements. Dr. Malone reported that appellant's right coronary artery was chronically occluded and that only part of the vessel was grafted. He reported that appellant had a history of recurrent chest pain when subjected to mental or emotional stress, particularly in the work setting. Dr. Malone opined that appellant was not employable at the age of 66 with his history of recurrent chest pain in the work environment.

Appellant's treating physician and OWCP's second opinion physician disagreed regarding his ability to return to his full-duty position and his need for ongoing medical treatment. As such, the Board finds that a conflict of medical opinion exists relative to these issues. OWCP should have resolved the conflict of medical opinion evidence before terminating compensation. As OWCP failed to resolve the conflicting medical opinion evidence, the Board finds that it failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits.[11]

## ***CONCLUSION***

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits.

[11] In light of the Board's disposition in Issue 1, Issue 2 is moot and will not be addressed in this appeal.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the April 13, 2016 decision of the Office of Workers' Compensation Programs is reversed.[12]

Issued: June 4, 2018
Washington, DC

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

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

[12] Colleen Duffy Kiko, Judge, participated in the original decision, but was no longer a member of the Board effective December 11, 2017.