

# Bulletins, Circulars, and Transmittals (BCT) FY 2011

This Folio InfoBase contains all Federal Employee Compensation Act (FECA) bulletins, circulars, and transmittals (BCT) along with Office of Workers' Compensation (OWCP) bulletins issued throughout Fiscal Year 2011 (FY11.)

All historic bulletins, circulars, and transmittals information can be found within the BCTINDEX InfoBase (FY-1986 to FY-2010.)

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## Federal Employee Compensation Act (FECA) Bulletins

### FECA BULLETIN NO. 11-01

**Issue Date:** February 2, 2011

**Subject:** Federal Reform Changes for Federal Benefits under the Affordable Care Act

**Background:** On March 23, 2010, President Obama signed the Affordable Care Act (ACA), Public Law 111-148. Several provisions of the ACA will affect the eligibility for a claimant's dependents under the Federal Employees Health Benefits (FEHB) Program beginning January 1, 2011.

**Purpose:** To inform the appropriate personnel of the changes to the FEHB that extends coverage to children up to age 26. Prior to the enactment of the ACA, coverage for a claimant's children under the FEHB ceased at age 22. The enactment of the new law now extends that cut-off age to 26. Note that the extended coverage is offered to all children/dependents under the age of 26, regardless of when they may have previously have lost their FEHB coverage. Also, children who lose coverage due to reaching age 26 are eligible for Temporary Continuation of Coverage (TCC) for up to 36 months, even if they previously had TCC.

**Applicability:** All National Office staff and District Office claims personnel.

**Actions:** The action required of the District Office to grant coverage to the newly eligible children depends upon the claimant's current FEHB enrollment:

- o If the claimant currently has a Self-and-Family enrollment and does not change to another health plan during Open Season, his or her current FEHB plan will contact him/her and provide information on the newly eligible child. There is no need to complete an SF-2809, Health Benefits Election Form, and no action is required of the District Office.

- o If the claimant has a Self-and-Family enrollment but elects a change to another

FEHB plan during Open Season, the District Office must ensure that all eligible children are listed on the SF-2809 when processing the change.

o If the claimant has a Self-Only enrollment and newly eligible children, they must change their enrollment from Self-Only to Self-and-Family. In order to make the change and extend coverage to the newly eligible children, the claimant must complete the SF-2809 to request the change, and the District Office must process the form like any other FEHB change request. In addition to processing the FEHB forms, the claimant's enrollment code should be updated in iFECS to reflect the new Self-and-Family coverage.

The effective date of coverage for newly eligible children depends upon the event used to change enrollment. All changes will be automatically processed as Open Season changes, with an effective date of January 16, 2011. However, the claimant has the option of extending coverage to the newly dependent child beginning January 1, 2011 as a "change in family status" qualifying life event (QLE). The qualifying life event code to use on the Health Benefits Election Form, SF-2809, is "2B" for OWCP recipients. Should the claimant make a QLE election rather than an Open Season change, the claimant must pay for the premiums for the period of January 1, 2011 to January 15, 2011.

**Disposition:** Retain until the procedures noted here are incorporated into the FECA Procedure Manual.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Attachments:

Distribution: List No. 1--Folioviews Groups A and D  
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists and Staff Nurses)

**Attachment to FECA Bulletin NO. 11-01**

**Affordable Care Act (ACA) - Changes in FEHB Coverage For Children**

Children between the ages of 22 and 26 are covered under their parent's Self-and-Family enrollment up to age 26.

Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.

Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.

Stepchildren do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.

Children who are incapable of self-support because of a mental or physical disability that began

before age 26 are eligible to continue coverage. Contact the National Office for further guidance.

Foster children are eligible for coverage up to age 26.

Note: Children **do not** have to live with their parent, be financially dependent upon their parent, or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB Program plans will send notice to all their enrollees of the coverage eligibility changes as a part of that plan's Open Season communications.

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**FECA BULLETIN NO. 11-02**

**Issue Date: March 3, 2011**

**Expiration Date: January 1, 2012**

**Subject:** Compensation Pay: Compensation Rate Changes Effective January 2011.

**Background:** On December 22, 2010, the President signed Executive Order 13561 implementing a salary freeze for the General Schedule basic pay. The rates of pay established for the 2010 GS Pay Schedule are to remain in effect through 2011. Normally, the applicability under 5 U.S.C. 8112 only includes an increase in the basic General Schedule, so no increase to the minimum or maximum rates of compensation will be afforded this year. Any additional increase for locality-based pay is excluded as always.

**Reference:** Memorandum for Executive Heads of Departments and Agencies dated December 22, 2010 and the attachment for the 2011 General Schedule.

**Purpose:** To inform the appropriate personnel of the minimum/maximum rates of compensation for affected cases on the periodic disability and death payrolls.

The maximum compensation rate payable is based on the scheduled salary of a GS-15, step 10, which remains \$129,517 per annum. The basis for the minimum compensation rate is the salary of a GS-2, Step 1 which remains \$20,017 per annum. The actual rates are outlined below.

Effective January 3, 2010, and continuing for 2011	Minimum	Maximum
Disability claims:		
Weekly	\$ 288.71	\$1,868.03
Daily (5-day week)	\$ 57.74	\$ 373.61
28-Day Cycle	\$1,154.83	\$7,472.13
Death claims:		
Monthly	\$1,668.08	\$8,094.81

**Action:** The Integrated Federal Employees' Compensation System (iFECS) will not require updates to the periodic disability and death payrolls as the rates have not changed since the prior adjustments were made.

**Applicability:** Appropriate National and District Office personnel.

**Disposition:** This bulletin is to be retained until the indicated expiration date.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 2 - Folioviews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists and Staff Nurses)

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**FECA BULLETIN NO. 11-03**

**Issue Date:** March 3, 2011

**Expiration Date:** February 29, 2012

**Subject:** Compensation Pay - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 2011.

**Reference:** FECA Consumer Price Index (CPI) Amendment, dated January 6, 1981 and Bureau of Labor Statistics Consumer Price Index Publication for December 2009 (USDL-10-0011).

**Purpose:** To furnish information on the CPI adjustment process for March 1, 2011.

The cost of living adjustments granted to compensation recipients under the FECA are based on the "Consumer Price Index for Urban Wage Earners and Clerical Workers" (CPI-W) figures published by the Bureau of Labor Statistics (BLS). The annual cost of living increase is calculated by comparing the base month from the prior year to the base month of the current year, with the percentage of increase adjusted to the nearest one-tenth of 1 percent, determining the amount of the CPI increase granted to claimants. 5 U.S.C. 8146(a) establishes the base month for the FECA CPI as December.

December 2009 had a CPI-W level of 211.703 and the December 2010 level was reported by BLS as 215.262. This means that the new CPI increase, adjusted to the nearest one-tenth of one percent, is 1.7 percent. The increase is effective March 1, 2011, and is applicable where disability or death occurred before March 1, 2010. In addition, the new base month for calculating the future CPI is December 2010.

The maximum compensation rates\* , which must not be exceeded, are as follows:

\$ 8,094.81 per month  
\$ 7,472.13 each four weeks  
\$ 1,868.03 per week  
\$ 373.61 per day (for a 5 day week)

\* Per Executive Order 13561 signed by President Obama on December 22, 2010, the GS pay schedules for Federal civilian employees will remain at 2010 levels for 2011 and 2012.

**Action:** National Office Production staff will update the Integrated Federal Employees' Compensation System (iFECS) CPI tables and have all payment records re-calculated when the iFECS system is not in use by District Office personnel. This will occur on or about March 1, 2011. The March 12, 2011 check will include the supplemental CPI payment for the period of March 1st to March 12th. The following periodic roll check will reflect the updated 28-day amount. Please note that if there are any cases with fixed gross overrides, there will be no supplemental record created. These cases must be reviewed to determine if CPI adjustments are necessary, and if so a manual calculation will be required. If the gross override payment is in fact eligible for annual CPI increases, the payment plate should be adjusted in the iFECS system to pay as a "Gross Override with CPI."

1. CPI Minimum and Maximum Adjustments Listings. Form CA-841 (Cost-of-Living Adjustments), Form CA-842 (Minimum Compensation Rates) and Form CA-843 (Maximum Compensation Rates) should be updated to indicate the rate for 2010. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966 through March 1, 2011, for reference.

2. Forms.

a. All claimants will be provided a notice with their Benefit Statements, indicating the amount of this year's increase. The Treasury will include this notice as a "stuffer card" with every Benefit Statement issued for the March 12, 2011 rolls.

b. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification, insurance verification, loan application, etc.), please continue to provide this data in letter form from the district office. Many times a Benefit Statement may not reach the addressee and regeneration of the form is not possible. A letter indicating the amount of compensation paid every four weeks will be an adequate substitute for this purpose.

**Applicability:** Appropriate National and District Office personnel.

**Disposition:** This bulletin is to be retained until the indicated expiration date.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 2 - Folioviews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists and Staff Nurses)

Attachment to FECA Bulletin 11-03 - **COST-OF-LIVING ADJUSTMENTS** Under 5 USC 8146(a)

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	03/01/87	0.7%
01/01/68	3.7%	03/01/88	4.5%
12/01/68	4.0%	03/01/89	4.4%
09/01/69	4.4%	03/01/90	4.5%
06/01/70	4.4%	03/01/91	6.1%
03/01/71	4.0%	03/01/92	2.8%
05/01/72	3.9%	03/01/93	2.9%
06/01/73	4.8%	03/01/94	2.5%
01/01/74	5.2%	03/01/94	2.5%
07/01/74	5.3%	03/01/95	2.7%
11/01/74	6.3%	03/01/96	2.5%
06/01/75	4.1%	03/01/97	3.3%
01/01/76	4.4%	03/01/98	1.5%
11/01/76	4.2%	03/01/99	1.6%
07/01/77	4.9%	03/01/00	2.8%
05/01/78	5.3%	03/01/01	3.3%
11/01/78	4.9%	03/01/02	1.3%
05/01/79	5.5%	03/01/03	2.4%
10/01/79	5.6%	03/01/04	1.6%
04/01/80	7.2%	03/01/05	3.4%
09/01/80	4.0%	03/01/06	3.5%
03/01/81	3.6%	03/01/07	2.4%
03/01/82	8.7%	03/01/08	4.3%
03/01/83	3.9%	03/01/09	0.0%
03/01/84	3.3%	03/01/10	3.4%
03/01/85	3.5%	03/01/11	1.7%
03/01/86	N/A		

Prior to September 7, 1974, the new compensation after adding the CPI is rounded to the nearest \$1.00 on a monthly basis or the nearest multiple of \$.23 on a weekly basis (\$.23, \$.46, \$.69, or \$.92). After September 7, 1974, the new compensation after adding the CPI is rounded to the nearest \$1.00 on a monthly basis or the nearest \$.25 on a weekly basis (\$.25, \$.50, \$.75, or \$1.00).

Prior to 09/07/74	.08-.34 = .23	Eff. 11/01/74	.13-.37 = .25
	.35-.57 = .46		.38-.62 = .50
	.58-.80 = .69		.63-.87 = .75
	.81-.07 = .92		.88-.12 = 1.00

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**FECA BULLETIN NO. 11-04**

**Issue Date: April 20, 2011**

**Subject:** Schedule A Initiative

**Background:** In support of Executive Order 13548 and President Obama's Protecting Our Workforce and Ensuring Re-employment (POWER) initiative, the Office of Workers' Compensation Programs' (OWCP) Division of Federal Employees' Compensation (DFEC) is prepared to launch a new initiative that utilizes the Schedule A non-competitive hiring authority to help rehire injured federal workers back into the federal government. Schedule A is an appointing authority, or hiring authority for the federal government. It is an Excepted Service appointment for persons with certain specific disabilities, including persons with mental retardation, severe physical disabilities, or psychiatric disabilities. The regulations guiding the *Excepted Service -- Appointment of Persons with Disabilities and Career-Conditional Appointment* are found in the Code of Federal Regulations (CFR). See 5 CFR § 213.3102(u).

The Executive Order (EO) states that the Department of Labor (DOL) and the Office of Personal Management (OPM) will work together to assist agencies in increasing the return-to-work rate of employees who suffer from work-related injury or illness. [Exec. Order No. 13548, 75 Fed. Reg. 45039 (July 26, 2010)]. The POWER initiative tasks agencies with a new goal of increasing the percentage of successful return-to-work for their injured employees. While the POWER return-to-work goal is set at the department level, the Executive Order does not specify that an injured worker must return to the same sub-agency or duty station. As a result, federal agencies have reason to search for employment opportunities at the department level. As OWCP has reason to seek return-to-work outcomes across the federal (and private) sectors, OWCP undertakes this Schedule A initiative in an effort to increase federal return-to-work outcomes.

In order to be eligible for Schedule A consideration, the applicable regulation states that the employee should have mental retardation, severe physical disability, or psychiatric disability. 5 C.F.R. § 213.3102(u)(1). The regulation does not include or exclude any particular type of disability under these three classes. Documentation of disability can be accepted from a licensed medical professional, a licensed vocational rehabilitation specialist, or "any Federal agency, State agency, or an agency of the District of Columbia or a U.S territory that issues or provides disability benefits." 5 C.F.R. § 213.3102(u)(2)(ii). Those same agencies may make certifications regarding an employee's job readiness. 5 C.F.R. § 213.3102(u)(3). As the Secretary of Labor has delegated the responsibility of administering the FECA to OWCP, OWCP is a federal agency that provides benefits due to injury or continuing total or partial disability, as well as schedule awards for the impairment and loss of use of schedule members, and OWCP has the authority to provide certification of Schedule A eligibility and certification of job readiness for appropriate injured claimants receiving FECA benefits.

As OWCP is a federal agency that issues or provides disability benefits, it will begin exercising this authority to work with agencies in utilizing all appropriate means of assisting them in returning injured workers to federal employment, including Schedule A certification.

**Purpose:** To provide guidance to claims staff, Rehabilitation Specialists, Rehabilitation Counselors, and Employing Agencies on the process for Schedule A certification and the steps DFEC will take to facilitate Schedule A placement.

**Applicability:** All National Office staff and District Office claims personnel, Staff Nurses, Rehabilitation Specialists, and Rehabilitation Counselors.

**Actions:**

1. **Timeline for Implementation.** Only two regions, the Northeast (New York and Boston) and the Southwest (Denver and Dallas) will participate in the first phase of the Schedule A Initiative, which will last approximately 120 days. After that period has elapsed, the process will be evaluated with a view toward expansion to other district offices.

2. **Rehabilitation Tracking System (RTS) and Disability Management (DM) Tracking Codes.** New codes will be used to document actions in cases reviewed for Schedule A placement.

DM	RTS	Initial Status (post referral)
SCC	AC	Schedule A Certified
SCR	AR	Schedule A Rejected

DM	RTS	Disposition Status (post certification)
SCD	AD	Schedule A Services Declined
SCW	AW	Schedule A RTW
SCO	AO	Schedule A RTW Other
SCN	AN	Schedule A Closed (No RTW)

3. **Guidelines for Identification of Suitable Candidates for Schedule A.** There are two components to consider when determining whether a claimant may be eligible for Schedule A certification.

**Medical** - In order to be eligible for the Schedule A initiative, the claimant must have certain medical conditions. When evaluating whether a claimant fits the medical criteria for Schedule A, the whole person is to be considered, not just the accepted work-related condition(s). For example, if the claimant has an accepted claim for carpal tunnel syndrome but is a paraplegic due to a non-employment related car accident, he or she would be an appropriate candidate for Schedule A placement.

The first class of conditions comprises the targeted disabilities which the federal government, as a matter of policy, has identified for special emphasis. A claimant who suffers from a targeted disability is an ideal candidate for this program. The targeted disabilities are: deafness, blindness, missing extremities, partial paralysis, complete paralysis, convulsive disorders, mental retardation, mental illness, and distortion of limb and/or spine.

In addition, OPM published guidance for agencies on the Executive Order on November 8, 2010, which provides additional, non-targeted disabilities. The guidance, titled *Model Strategies for Recruitment and Hiring of People with Disabilities as Required Under Executive Order 13548*, can be found at the following

website.

<http://www.chcoc.gov/Transmittals/TransmittalDetails.aspx?TransmittalID=3228>

**Attachment 1** (Targeted Disabilities and Non-Targeted Disabilities Chart from November 8, 2010 OPM Memorandum titled, *Model Strategies for Recruitment and Hiring of People with Disabilities as Required Under Executive Order 13548*) outlines the specific targeted and non-targeted disabilities. This chart should be consulted to determine if the individual has a qualifying condition that could be considered for Schedule A.

Twenty-one (21) conditions are listed as non-targeted disabilities, including the following: non-paralytic orthopedic impairments, cardiovascular/heart disease, diabetes, pulmonary/respiratory conditions, gastrointestinal disorders, cancer, and disfigurement. If the claimant's disability is due to a non-paralytic orthopedic impairment (without other qualifying employment or non-employment related conditions), the claimant must be at the sedentary or sub-sedentary level in order to be eligible for Schedule A certification by DFEC.

**Vocational** – As Schedule A placement is offered in addition to routine placement services, the claimant should be determined to be eligible for vocational rehabilitation services.

The Rehabilitation Specialist, in addition to considering the claimant for Schedule A placement, should also still identify at least two targeted jobs that are vocationally and medically suitable (via form OWCP-66) during the plan development phase. The services that are needed prior to placement should be provided (transferable skills analysis, testing, training, resume assistance, etc.), and the claimant should usually be work-ready when referred for Schedule A placement.

**4. The Role of the Rehabilitation Specialist.** Certain District Office Rehabilitation Specialists (DO RS) will be designated as Schedule A Rehabilitation Specialists (SA RS). An SA RS may provide Schedule A certification for claimants within his or her own district, as well as other districts.

The DO RS will refer individuals who meet eligibility requirements, as discussed above, to the SA RS for review. The SA RS will provide the necessary Schedule A certification, if appropriate, and work with the DO RS to facilitate a Schedule A placement. The DO RS, however, remains the primary manager of the rehabilitation case, as Schedule A certification and placement remains only one component of a rehabilitation plan.

**5. Referral of Cases.** The identification of Schedule A candidates should be made as early in the rehabilitation process as possible, ideally during the plan development phase.

During the plan development phase, the DO RS should review cases with the assigned Rehabilitation Counselor (RC) to determine whether an individual may be a possible candidate for Schedule A placement. This determination consists of the medical and vocational elements outlined in #3 of this bulletin, but the DO RS should also consider the claimant's motivation, especially the desire to return to federal

employment. Since Schedule A placement infers a self-certification of disability, the claimant should be motivated to return to work with the federal government. The DO RS may discuss this possibility with the claimant if there is any question regarding this element.

Once the DO RS has identified a claimant who may be a suitable candidate for Schedule A placement, he or she will complete a referral form and place it into the case. The SA RS will then be notified of the referral.

The referral should include the following information: claim number, claimant name, date of injury, accepted condition(s), concurrent condition(s), whether the case is being referred based on a targeted or non-targeted qualifying disability, the targeted or non-targeted qualifying disability, and available vocational background (degree(s), date of transferable skills analysis, work history or resume, job held when injured with position description, etc.). The referral should also indicate whether the DO RS or RC has discussed the Schedule A option with the claimant and, if not, how the determination was made that the claimant may be motivated to return to federal employment via this option.

**6. Review and Disposition of Referrals.** The SA RS will review the referral in conjunction with the case file to determine whether the claimant can be certified for Schedule A placement. This review should take place within five business days of the DO RS referral.

If the claimant is not a good candidate for Schedule A, the SA RS will document the file with the reasons why the claimant cannot be provided Schedule A placement services and notify the DO RS. The DO RS will code the case in RTS as **AR** (Schedule A Rejected). The DO RS will also notify the assigned RC and the Claims Examiner (CE). The CE will enter the **SCR** (Schedule A Rejected) code in DM. In the event the claimant wishes further consideration for Schedule A placement, the claimant should be provided a letter that outlines the reasons for denial of the placement services. The letter should include the option to have that determination reviewed, based on any new evidence/argument submitted, by someone not involved in the prior determination.

If the claimant is a good candidate for Schedule A, the SA RS will issue a letter to the claimant outlining the Schedule A hiring authority. This letter will also serve as notification that the claimant has been approved for such authority, and a proposed time and date for a conference call to discuss the process within the next five days will be suggested. **Attachment 2**, Schedule A Certification Letter to Claimant, is a sample of this correspondence.

**7. Conference Call.** The SA RS will schedule a conference call with the DO RS, the RC, and the claimant. During this call, the Schedule A hiring authority will be explained in more detail, and the SA RS will let the various stakeholders know what to expect in the next months. During the conference call, however, it is important that the claimant understand that Schedule A placement is not guaranteed, and that this is only one tool being used to facilitate the return-to-work effort.

The call should be held as soon as possible after the certification letter is sent, preferably within 5 days. A brief memorandum of conference should be placed in the

claim file once the conference is completed.

**8. Schedule A Placement Services Declined.** If, after the conference call (or any time thereafter), the claimant indicates that he or she does not want to proceed with Schedule A placement services, the SA RS should document the file accordingly and notify the DO RS (if he or she is not already privy to the information through the conference call). The DO RS will code RTS as **AD** (Schedule A Services Declined) and notify the assigned RC and the CE. The CE will enter the **SCD** (Schedule A Services Declined) code in DM.

Note - Participation in the Schedule A placement process is entirely voluntary; therefore, sanctions for non-cooperation with the rehabilitation process (or refusal of suitable employment) will not be imposed if the claimant decides not to participate in Schedule A placement for any reason.

**9. Schedule A Placement Services Accepted.** If the claimant wishes to continue with Schedule A placement services, in addition to the usual rehabilitation placement services for a job in the private sector, both the SA RS and the DO RS have specific responsibilities.

SA RS Actions - Depending on the phase of rehabilitation, the SA RS will prepare a disability certification or a combined disability and job-readiness certification.

If the claimant is job ready at the time of the certification, the SA RS will issue one letter that certifies both the disability and job readiness (see **Attachment 3**, Schedule A Disability and Job-Readiness Certification). If the claimant is certified for Schedule A during the plan development phase because he or she has an eligible disability but is not yet work ready, the disability certification may be issued first (see **Attachment 4**, Schedule A Disability Certification). Then, once the placement phase begins, the DO RS should notify the SA RS so that an updated certification for both disability and job readiness can be issued. This may occur if, for instance, the claimant needed short-term training but there was a possibility that the employing agency might have work for the individual in another area.

The appropriate certification letters should be issued within 5 working days of the conference call wherein the claimant agreed with Schedule A placement services, or within 5 working days of the start of the placement phase, whichever is applicable.

DO RS Actions – When the first certification letter is issued, the DO RS will be notified, who in turn will notify the RC and the CE. The DO RS will code the case in RTS as **AC** (Schedule A Certified) and the CE will enter the **SCC** (Schedule A Certified) code in DM.

Most Federal agencies have a Selective Placement Program Coordinator (SPS), a Special Emphasis Manager (SEM) for Employment of Adults with Disabilities, or equivalent, who helps to recruit, hire, and accommodate people with disabilities at that agency. Once the DO RS receives the certification documents, he or she should contact the department or agency where the claimant worked at the time of injury to indicate that this claimant is ready to work and is Schedule A certified. A list of these personnel at each federal agency is provided on the OPM website at:

[http://apps.opm.gov/sppc\\_directory/](http://apps.opm.gov/sppc_directory/)

Once contact has been made, the DO RS should forward the claimant's resume to the SPC and ask that he or she identify any current openings at the department or agency for which the claimant would be qualified.

In addition, the DO RS (and RC) should perform searches of USA Jobs and other similar federal job sites to identify positions in other departments and agencies (beyond where the claimant worked at the time of injury) for which the claimant is qualified. If the DO RS or RC finds a specific posting for which the claimant may be qualified, the position should then be discussed with the claimant. If the claimant is interested, then the DO RS should contact the appropriate SPC and arrange to submit the claimant's resume for consideration. If an agency expresses interest in hiring the claimant under Schedule A and the claimant is interested in the position, the DO RS can provide the certification documentation that was prepared by the Schedule A RS.

If the DO RS has difficulty in reaching the SPC or in identifying positions for the claimant, the SA RS will act as a source of information and advice, and perhaps liaise with other federal agencies.

Note - It is also important to note that Schedule A involves excepted-service appointments. Agencies are authorized to categorize the Schedule A appointments as either permanent or term-limited based on (i) proof of disability and (ii) a certification of job readiness or a demonstration of job readiness through a temporary appointment. Agencies also have the option of making Schedule A temporary appointments where it may be necessary to observe whether a potential appointee is able to perform the requirements of the position. After two years of satisfactory performance, agencies may non-competitively convert Schedule A appointees, who served in non-temporary appointments, to competitive service positions. As these situations may vary, the claimant should be informed of the possibility that Agencies' decisions to convert an excepted-service appointment to competitive service at the end of two years are discretionary. Claimants are encouraged to discuss these issues and any necessary accommodations with the federal employer of the Office of Personnel Management (OPM).

**10. Period of Services.** The Schedule A placement initiative does not alter the usual parameters of vocational rehabilitation. Ninety (90) days of placement services are provided as part of the rehabilitation process, and the Schedule A certification does not change this timeframe. However, one sixty (60) day extension may be granted if the DO RS and/or the SA RS have reason to believe that it will lead to a placement under Schedule A. The rationale for any such extension should be documented in the file.

**11. Return to Work via Schedule A.** If the claimant returns to work via the Schedule A hiring authority, the file should be clearly documented with the specifics of the return to work. The DO RS should then code RTS as **AW** (Schedule A RTW) and alert the SA RS and CE. The CE should enter the **SCW** (Schedule A RTW) code in DM.

Along with the Schedule A disposition codes, the RS should still enter the usual RTS codes to document the return to work. For example, if the claimant was Schedule A

certified and returned to work with the previous employer through the Schedule A hiring authority, the RS should enter the following in RTS to document the Schedule A return to work: code AC (Schedule A Certified) when the certification letter is sent to the claimant; code W (Placement previous employer, with other services); code AW (Schedule A RTW); code E (Employed); and then after 60 days of successful work closure code 4 (Closed Rehabilitated-Previous Employer).

After 60 days of employment, the CE will review the case to determine whether a formal Loss of Wage-Earning Capacity (LWEC) decision is appropriate.

Note – Whether the claimant returned to work with the “previous employer” is determined at the department, not agency, level. For instance, a claimant who was employed as a Park Ranger with the National Park Service and returns to work with the Bureau of Land Management is considered placed with his “previous employer,” as both agencies fall under the Department of the Interior. Placement in another government position, outside the original Department, would qualify as a Code 2 – Placement with a New Employer.

12. **Return to Work – Not Schedule A.** If the claimant returns to work without the use of the Schedule A hiring authority, the file should be documented with the specifics of the return to work. The DO RS should notify the SA RS and the usual rehabilitation closure procedures should be followed. However, prior to entering the Employed (E) code in RTS, the DO RS should enter **AO** (Schedule A RTW Other) to document the disposition of the Schedule A certification. The CE should also be notified and should enter the **SCO** (Schedule A RTW Other) code in DM.

13. **Placement Ends – No Return to Work.** If the vocational rehabilitation placement period ends, the normal process for issuing a constructed LWEC decision may be considered in accordance 5 U.S.C 8115. The Schedule A initiative has no impact and should **not** be referenced in the FECA entitlement decision in these cases. However, if the placement period ends for a case in which the claimant was Schedule A Certified and there was no return to work, the DO RS should notify the SA RS and the CE, and then code RTS with **AN** (Schedule A Closed, No RTW) prior to entering a closure code. Upon notification, the CE should enter code **SCN** (Schedule A Closed, No RTW) in DM.

14. **File Documentation.** A separate Schedule A file should be made for each candidate who is considered for Schedule A placement services pursuant to the Privacy Act System DOL/ESA-43, which covers OWCP Rehabilitation Files. The DO RS should maintain this file, but all documentation should also be made part of the claimant’s case file. The Schedule A file should contain the following documentation: Schedule A referral; certification letter to claimant or document with rationale for rejecting the case; claimant resume, date of injury position description and transferable skills analysis, if available; history of contacts on behalf of the claimant with an aim at securing employment via the Schedule A hiring authority; and the job description for the position obtained or other applicable closure documentation.

15. The Schedule A certification process is **not** a FECA entitlement determination and is **not** subject to the FECA appeal process.

Disposition: Retain until the procedures noted here are incorporated into the FECA Procedure Manual.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation  
Attachments:

Distribution: List No. 1--Folioviews Groups A and D  
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers,  
Technical Assistants, Rehabilitation Specialists and Staff Nurses)

Attachment 1 to Bulletin 11–04 –

Targeted Disabilities and Non-Targeted Disabilities Chart from November 8, 2010 OPM Memorandum titled, *Model Strategies for Recruitment and Hiring of People with Disabilities as Required Under Executive Order 13548*

Targeted Disabilities (Severe)

New SF 256 Category	Old SF 256 Category	New Code & Definition	Previous Code & Definition
Hearing	Hearing Impairments	18- Total deafness in both ears (with or without understandable speech)	16- Total deafness in both ears, with understandable speech. 17- Total deafness in both ears, and unable to speak clearly.
Vision	Vision Impairments	21- Blind (inability to read ordinary size print, not correctable by glasses, or no usable vision, beyond light perception)	23- Inability to read ordinary size print, not correctable by glasses (Can read oversized print or use assisting devices such as glass or projector modifier). 25- Blind in both eyes (No usable vision, but may have some light perception)
Missing Extremities	Missing Extremities	30- Missing extremities (missing one arm or leg, both hands or arms, both feet or legs, one hand or arm and both feet or legs, both hands or arms and one foot or leg, or both hands or arms and both feet or legs)	28- One arm 32- One leg 33- Both hands or arms 34- Both feet or legs 35- One hand or arm and one foot or leg 36- One hand or arm and both feet or legs 37- Both hands or arms and one foot or leg 38- Both hands or arms and both feet or legs
Partial Paralysis	Partial Paralysis	69- Partial paralysis (because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including both hands; any part of both arms or	64- Both hands 65- Both legs, any part 66- Both arms, any part 67- One side of body, including one arm and one leg 68- Three or more major parts of the body (arms and legs)

		legs; one side of the body, including one arm and one leg; and/or three or more major body parts)	
Complete Paralysis	Complete Paralysis	79- because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including both hands; one or both arms or legs; the lower half of the body; one side of the body, including one arm and one leg; and/or three or more major body parts	71- Both hands 72- One arm 73- Both arms 74- One leg 75- Both legs 76- Lower half of body, including legs 77- One side of body, including one arm and one leg 78- Three or more major parts of the body (arms and legs)
Other Impairments	Other Impairments	82- Epilepsy	82- Convulsive disorder (e.g. epilepsy)
		90- Severe intellectual disability	90- Mental retardation (A chronic and lifelong condition involving a limited ability to learn, to be educated, and to be trained for useful productive employment as certified by a State Vocational Rehabilitation agency under section 213.3102(t) of Schedule A)
		91- Psychiatric disability	91- Mental or emotional illness (A history of treatment for mental or emotional problems)
		92- Dwarfism	92- Severe distortion of limbs and/or spine (e.g. dwarfism, kyphosis [severe distortion of back])

Non-targeted Disabilities

New SF 256 Category	Old SF 256 Category	New Code & Definition	Previous Code & Definition
Hearing Conditions	Hearing Impairments	15- Hearing impairment/hard of	15- Hard of hearing (Total deafness in one

		hearing	ear or inability to hear ordinary conversation, correctable with a hearing aid)
Vision Conditions	Vision Impairments	22- Visual impairments (e.g., tunnel or monocular vision or blind in one eye)	22- Ability to read ordinary size print with glasses, but with loss of peripheral (side) vision (Restriction of the visual field to the extent that mobility is affected- "Tunnel vision") 24- Blind in one eye
Physical Conditions	Missing Extremities	26- Missing Extremities (one hand, one foot, or one hand and one foot)	27- One hand 29- One foot
	[New code: no corresponding old category name.]	40- Mobility impairment	[New code: no corresponding old code.]
		41- Spinal abnormalities (e.g., spina bifida, scoliosis)	[New code: no corresponding old code.]
		51- HIV Positive/AIDS	[New code: no corresponding old code.]
		52- Morbid obesity	[New code: no corresponding old code.]
		95 - Gastrointestinal disorders (e.g., Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia, etc.)	[New code: no corresponding old code.]
		98 - History of alcoholism	[New code: no corresponding old code.]

	Non-paralytic Orthopedic Impairments (Because of chronic pain, stiffness, or weakness in bones or joints, there is some loss of ability to move or use a part or parts of the body)	44- Non-paralytic orthopedic impairments: chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body	44- One or both hands 45- One or both feet 46- One or both arms 47- One or both legs 48- Hip or pelvis 49- Back 57- Any combination of two or more parts of the body
	Partial Paralysis	61- Partial paralysis of one hand, arm, foot, leg, or any part thereof	61- One hand 62- One arm, any part 63- One leg, any part
	Complete Paralysis	70- Complete paralysis of one hand	70- One hand
	Other Impairments	80- Cardiovascular/heart disease with or without restrictions or limitation on activity; a history of heart problems w/ complete recovery	80- Heart disease with no restriction or limitation of activity (History of heart problems with complete recovery) 81- Heart disease with restriction of limitation of activity
		83 - Blood diseases (e.g., sickle cell anemia, hemophilia)	[Roughly same as new code. Inserted for reference.]
		84 - Diabetes	[Roughly same as new code. Inserted for reference.]
		86 - Pulmonary or respiratory conditions (e.g., tuberculosis, asthma, emphysema, etc.)	[Roughly same as new code. Inserted for reference.]
		87 - Kidney dysfunction (e.g., required dialysis)	[Roughly same as new code. Inserted for reference.]
		88- Cancer (Present or past history)	88- Cancer- a history of cancer with complete recovery 89- Cancer- undergoing surgical and/or medical treatment

		93 - Disfigurement of face, hands, or feet (such as those caused by burns or gunshot wounds) and noticeable gross facial birthmarks	[Roughly same as new code. Inserted for reference.]
Speech/Language/Learning Conditions	Speech Impairments	13 - Speech impairment - includes impairments of articulation (unclear language sounds), fluency (stuttering), voice (with normal hearing), dysphasia, or history of laryngectomy	[Roughly same as new code. Inserted for reference.]
	Other Impairments	94 - Learning disability - a disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts (spoken or written) (e.g., dyslexia, ADD/ADHD)	[Roughly same as new code. Inserted for reference.]

## **Attachment 2 to Bulletin 11–04 -**

### **Schedule A Certification Letter to Claimant**

Dear (Claimant Name),

The Office of Workers' Compensation Programs (OWCP) is committed to utilizing all available resources to assist you in returning to gainful employment. A review of your claim reveals that you are a candidate for placement services under the Schedule A hiring authority, which may allow you to return to work with the federal government.

The Federal Government has special appointing authorities for persons with disabilities. Schedule A is an excepted service hiring authority which allows agencies to hire disabled workers without requiring them to compete for the job. The enclosed pamphlet from the Office of Disability Employment Policy provides more information about Schedule A. To be eligible for these noncompetitive, Schedule A appointments, the applicant has to meet certain medical criteria. OWCP has determined that you meet these criteria and is going to certify that you are eligible for this special hiring authority.

In addition to the services being provided to place you in a new position in the private sector, OWCP will provide you with the necessary Schedule A certification documentation, contact federal agencies on your behalf, and conduct job searches for federal jobs that match your qualifications. You will be provided resume preparation assistance, interview coaching, and other services that will assist with your job search.

In order to ensure that you understand this process and can get any questions answered, we would like to conduct a conference call on [insert date] at [insert time]. Your Rehabilitation Counselor will participate in this call, as well as the Rehabilitation Specialist from [insert district office name]. I will call you at [insert phone number], so please contact me if this number is incorrect. If you are unable to participate in a conference call at this time, please contact me so that it can be rescheduled.

I look forward to working with you over the next few months. Please do not hesitate to contact me with any questions.

Sincerely,

(Schedule A RS Name)  
Schedule A Rehabilitation Specialist

**Attachment 3 to Bulletin 11-04 -**

**Schedule A Disability and Job Readiness Certification**

To Whom It May Concern:

This letter serves as certification that (name of claimant) is an individual with a severe physical, intellectual, or psychological disability that qualifies him/her for consideration under 5 CFR §213.3102 (u), Schedule A hiring authority, appointment for Persons with Disabilities.

Additionally, this employee is certified as job ready in a \_\_\_\_\_ (ex: office, food worker, warehouse) setting and is likely to succeed in performing the duties of the position he/she is seeking.

I may be contacted at (address and phone number).

Thank you for your interest in considering this individual for employment.

(Schedule A RS Name)  
Schedule A Rehabilitation Specialist

**Attachment 4 to Bulletin 11–04 -**

**Schedule A Disability Certification**

To Whom It May Concern:

This letter serves as certification that (name of claimant) is an individual with a severe physical, intellectual, or psychological disability that qualifies him/her for consideration under 5 CFR §213.3102 (u), Schedule A hiring authority, appointment for Persons with Disabilities.

I may be contacted at (address and phone number).

Thank you for your interest in considering this individual for employment.

(Schedule A RS Name)  
Schedule A Rehabilitation Specialist

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**FECA BULLETIN NO. 11–05**

**Issue Date: May 3, 2011**

**Subject:** Usage Guidelines for Fentanyl Products

**Background:** The National Institute on Drug Abuse identified fentanyl, an extremely potent narcotic, as an emerging drug of abuse with multiple deaths reported annually due to its abuse. There are two formulations of this narcotic: fast-acting and sustained-release. The fast-acting formulation is highly addictive and is indicated only for the treatment of break-through pain for those with cancer-related pain not controlled using conventional narcotic pain medications. Its use for other conditions creates an unacceptable high risk for addiction, and narcotic addiction impairs a worker's ability to return to meaningful employment.

Under the Federal Employees' Compensation Act (FECA), the Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP) may provide to an employee injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers "likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation." See 5 U.S.C. 8103.

In accordance with the discretion granted to DOL and delegated to OWCP, OWCP's Division of Federal Employees' Compensation (DFEC) is instituting a new policy and program to monitor and closely manage the use of fast-acting fentanyl products such as Actiq and Fentora and the prescribing of parenteral fentanyl products.

The new policy does not preclude prescribing fast-acting or parenteral fentanyl for any claimant with a work-related cancer diagnosis.

**Purpose:** To provide guidance to claims staff on the use of fast-acting fentanyl products, and how to manage cases where a claimant is receiving such a product for a work-related condition other than cancer.

**Action:**

1. A new medication authorization automatic processing rule is being implemented whereby prescriptions for fast-acting fentanyl products will deny unless the claimant has an accepted work-related condition of cancer. Note however that not all cancers will meet the criteria for the authorization of fentanyl. The following cancers will not be covered: non-melanoma cancers of the skin and *carcinoma in situ*. Also, benign tumors, by definition, are not cancer; thus, fentanyl use is not authorized.

2. Those claimants currently receiving fast-acting fentanyl products who do NOT have cancer will need additional case management.

3. For any claimant currently receiving a fast-acting fentanyl product who does not have an accepted condition of cancer, the Claims Examiner (CE) should release a letter to the physician outlining DFEC's new policy and requesting an updated treatment plan that does not include fast-acting fentanyl products within 30 days.

See attachment 1 of this bulletin for a sample of that letter. A copy of the letter should also be sent to the claimant.

4. If the physician updates the treatment plan to omit fast-acting fentanyl products, no further action is needed. Likewise, if no response is received from the claimant or the physician, no further action is needed, as it will be assumed that an alternative method of treatment has been chosen.

5. If the claimant responds without any medical documentation from his/her physician, the claimant should be directed back to his/her treating physician.

6. If the physician responds back with an indication that a fast-acting fentanyl product is an appropriate treatment for the claimant's accepted condition(s), the case should be reviewed in detail in conjunction with the physician's response. The CE should respond based on the specific information in the case and again request the physician to choose an alternative treatment regimen, since OWCP will cease payment for any fast-acting fentanyl product.

7. If there is any indication of addiction to the fast-acting fentanyl product, the CE can also alert the physician and the claimant that treatment for substance abuse can be authorized at OWCP expense.

As outlined in FECA Procedure Manual 2-0813-16 and 3-0400-5(b)(4), ordinarily inpatient care will be limited to a one-time 28-day stay at a reputable facility, though in unusual circumstances additional inpatient care may be authorized. Outpatient treatment may also be approved by itself or as a follow-up measure to inpatient care. Likewise, counseling in a group setting may be undertaken at OWCP expense.

8. If necessary, guidance from the office District Medical Advisor (DMA) can be obtained. The case may also be reviewed by the OWCP Medical Director if deemed warranted.

9. After notice has been provided and authorization for alternative treatment regimens has been extended, payment for all fast-acting fentanyl products for claimants without a work-related cancer condition will cease. If necessary, a formal decision denying such medication can be issued after all necessary development, providing that notice has been provided.

**Applicability:** Appropriate National and District Office personnel.

**Disposition:** This bulletin is to be retained until the Procedure Manual is updated.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 2 – Folioviews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists and Staff Nurses)  
Attachment to FECA Bulletin 11–05

### **LETTER TO PHYSICIAN AND CLAIMANT – CURRENT FENTANYL USE**

Dear NAME OF PHYSICIAN:

According to our records, you are treating CLAIMANT'S NAME under the provisions of the Federal Employees' Compensation Act (FECA). You are receiving this letter because our records indicate that this worker is being prescribed a fentanyl product by your office.

Under the FECA, the Department of Labor's (DOL) OWCP may provide to an employee injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers "likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation." See 5 U.S.C. 8103. In accordance with the discretion granted to DOL and delegated to OWCP, OWCP is undertaking a review of certain prescription drugs and their usage. OWCP's Division of Federal Employees' Compensation (DFEC) is instituting a new policy and program to monitor and manage the use of fast-acting fentanyl products such as Actiq and Fentora and the prescribing of parenteral fentanyl products.

One goal of this policy is to severely limit the use of fentanyl products. While this does not preclude prescribing fast-acting or parenteral fentanyl for claimants who

have a diagnosis of cancer that has been accepted as work-related, this individual's case has not been accepted for cancer. The case has been accepted for the following work-related conditions: LIST ACCEPTED CONDITIONS.

[Optional paragraph if more than one fentanyl-prescribing provider]  
To ensure you are aware of the complete extent of your patient's use of these products, our records indicate that you are one of TOTAL NUMBER providers prescribing fast-acting fentanyl for this worker.

Narcotics usage can impair a worker's ability to return to and maintain meaningful employment. Appropriate pain management involves developing a treatment plan detailing the use of available non-narcotic modalities to include mental health evaluation and therapy, pain control clinics, and alternative pain-control modalities focused on reduction or elimination of narcotic pain relievers. DFEC may authorize various types of pain management therapies in lieu of narcotics that would enable a worker's return to employment.

CLAIMANT'S NAME case will be reviewed again in 30 days. Please submit and/or update a narrative treatment plan for this individual, taking into account DFEC's new limitation on fentanyl products, within that time frame. If you desire additional information, please do not hesitate to contact our office; your inquiry may be referred to the OWCP Medical Director if deemed warranted.

Sincerely,

CLAIMS EXAMINER

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**FECA BULLETIN NO. 11 – 06**

**Issue Date: August 4, 2011**

**Subject: DFEC Regulations, Published June 28, 2011**

**Background:** Prior to this update, the program's regulations were last substantially revised in 1999. Since then, the organization and authority of the Office of Workers' Compensation Programs (OWCP) has changed, new provisions have been added to the statute, and experience has shown that certain parts of the regulations needed clarification or revision to promote fairness and efficiency in the claims process. In addition, the Division of Federal Employees' Compensation (DFEC) has made substantial technological advances that helped preserve administrative resources and improve efficiency in the claims process since the 1999 regulations. OWCP determined that the regulations governing the administration of the Federal Employees' Compensation Act (FECA) required updating.

OWCP's Notice of Proposed Rulemaking was published in the Federal Register on August 13, 2010, and the comment period closed on October 12, 2010. After review of all comments submitted, the Final Rule was published on June 28, 2011, **effective as of August 29, 2011**. Even though this most recent update is not a wholesale revision of the existing regulations, consistent with past practice, the entire regulation was republished for ease of use.

**Purpose:** Procedure Manual updates, where necessary, are forthcoming. In the interim, this bulletin provides a brief synopsis of the regulations that were substantively changed and a description of those changes.

## **20 CFR Part 1**

This subpart has been amended to reflect the change in organization at the Department of Labor that occurred on November 8, 2009, when the Employment Standards Administration (ESA) was dissolved and the authority that the Secretary of Labor had previously delegated under the Federal Employees' Compensation Act (FECA) to ESA was delegated by the Secretary to the Director, OWCP.

## **20 CFR Part 10**

### **Subpart A -- General Provisions**

This subpart is substantially the same as the prior subpart A (§§10.0 through 10.18). The majority of the changes to this subpart involved updating the regulations as a result of the addition of the new death gratuity benefit which was added to the FECA by 5 U.S.C. 8102a, and by adding clarification language in a number of sections.

#### **Definitions and Forms**

Section 10.2 now includes the new subpart J of this part which administers the death gratuity benefit that was added to the FECA in 2008 by 5 U.S.C. 8102a.

Section 10.5 has been revised to restore the FECA statutory definitions and citations, as the absence of these citations has at times caused confusion regarding what definitions were applicable. 10.5(x) was updated to clarify the definition of a recurrence of disability.

Section 10.6 now includes a reference to the special definitions for survivorship and dependency that apply only to the new death gratuity benefit to promote clarity.

Section 10.7 has been updated to list all new forms described above and to eliminate forms that are no longer in use.

#### **Information in Program Records**

Section 10.10 has been amended to state that information may be released under the Privacy Act through the routine uses that apply to the records if such release is consistent with the purpose for which the records were created.

#### **Rights and Penalties**

Section 10.16 has been revised to note that a civil action may be maintained under the False Claims Act to recover erroneous payments under the FECA.

Section 10.17 has been revised to clarify when benefits are terminated for defrauding the Federal Government to eliminate confusion concerning what day should be used when a guilty plea has been entered. When a beneficiary either pleads guilty to or is found guilty on either Federal or State criminal charges of defrauding the Federal Government in connection with a claim for benefits, the beneficiary's entitlement to any further compensation benefits will terminate effective the date of conviction, which is the date of the verdict, or, in the case of a plea bargain, the date the claimant made the plea in open court (not the date of sentencing or the date court papers were signed). This section was also updated to note that the employing agency shall provide the documentation needed for termination under this section, and that termination of entitlement under this section is not affected by any subsequent change in or recurrence of the beneficiary's medical condition.

Section 10.18 has been revised to provide an affirmative duty for a beneficiary to report to OWCP any incarceration based on a felony conviction that would result in forfeiture of that beneficiary's right to compensation during incarceration.

### **Subpart B – Filing Notices and Claims; Submitting Evidence**

This subpart is substantially the same as the prior subpart B (§§10.100 through 10.127). Most changes involve the electronic submission of forms. Other changes include the administration of the change to the waiting period for employees of the United States Postal Service necessitated by a statutory amendment in 5 U.S.C. 8117.

#### **Notices and Claims for Injury, Disease, and Death—Employee or Survivor's Actions**

Sections 10.100, 10.101, 10.102, 10.103 and 10.105 all have been revised by an identical provision that allows for electronic submission of notices and claims forms. This change includes a provision that all agencies should create a method to submit such forms electronically by December 31, 2012, by which time OWCP will have implemented a method to enhance the agencies' ability to file forms electronically.

Section 10.102 was also revised to reflect that form CA-8 is no longer used and that form CA-7 should be used to claim compensation for additional periods of disability.

Section 10.103 has been revised to provide authority to create a separate form for schedule award claims under 5 U.S.C. 8107. A separate form, however, has not been created at this time.

Section 10.104 was revised to make clear what constitutes a recurrence of disability and to explain the basis for modification of a loss of wage-earning capacity determination. The addition of paragraph (c) to this section clarifies the distinction by incorporating longstanding case law from the Employees' Compensation Appeals Board (ECAB). OWCP, however, maintained authority to adjudicate a limited period of disability following the issuance of a loss of

wage-earning capacity decision, e.g. where an employee has a demonstrated need for surgery.

### **Notices and Claims for Injury, Disease, and Death--Employer's Actions**

Section 10.111 has been amended to reflect the change in law regarding waiting periods for Postal Service employees incorporated in the amendment to 5 U.S.C. 8117. 10.111(d) outlines that Postal Service employees are not entitled to compensation or continuation of pay for the waiting period, the first three days of disability, unless disability exceeds 14 days.

### **Evidence and Burden of Proof**

Section 10.115 has been revised to clearly state that the burden of proof remains with the claimant even when OWCP requests additional information, as provided by ECAB case law.

### **Decisions on Entitlement to Benefits**

Section 10.127 has been amended to remove the language stating that service of a decision on either the claimant or the representative would count as service to both, as this no longer reflects current practice of the OWCP. OWCP serves decisions on entitlement to both the claimant and the representative.

## **Subpart C--Continuation of Pay**

Subpart C (§§10.200 through 10.224) continues unchanged from the prior regulations, except for a change to §10.200. The change to this section reflects the change to continuation of pay for Postal Service employees as a result of the statutory change to 5 U.S.C. 8117, which provides that Postal Service employees are not entitled to continuation of pay for the first 3 days of temporary disability unless that disability exceeds 14 days or is followed by permanent disability.

## **Subpart D—Medical and Related Benefits**

Subpart D (§§10.300 through 10.337) is mostly unchanged. Most of the changes involve technological advances since the last update of the regulations which caused procedures to be changed. Other changes clarify the prior regulations or codify current practice.

### **Emergency Medical Care**

Section 10.300 has been amended to clarify that the Form CA-16, which provides authorization for initial medical treatment, authorizes treatment from the date of injury, not the date the form is signed. Part 6 of the CA-16 has been updated to reflect this change.

### **Medical Treatment and Related Issues**

Section 10.310 has been amended in a number of places. It has been modified to codify OWCP's authority to utilize field nurses in facilitating and coordinating medical care and amended to clearly state that certain non-physician providers (such as physician's assistants, nurse practitioners, and physical therapists) may provide authorized services to injured employees, to

the extent allowed under Federal and state law including licensure by any appropriate regulating body for that profession. This section was also updated to codify OWCP's authority to contract with specific providers to provide services and appliances; outline specific requirements for providers of Durable Medical Equipment; and allow OWCP to offset the costs of prior rental payments against a future purchase and provide refurbished equipment when appropriate in order to help control the cost of providing this equipment.

Section 10.311(d) has been amended to clarify that chiropractors can only provide physical therapy services under the direction of, or as prescribed by, a qualified physician.

Section 10.314 relating to attendant services has been substantially shortened from the prior regulation. This section outlines that OWCP will pay for the services of an attendant under section 8103 of the Act, instead of section 8111(a), as long as services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual. Existing attendant allowance payments initiated prior to January 4, 1999 made under 5 U.S.C. 8111(a) will continue.

Section 10.315 has been substantially modified, increasing the reasonable distance of travel up to a **roundtrip distance of 100 miles**. This section has also been amended to explain that travel should be undertaken by the shortest route, and, if practical, by public conveyance; however, if the medical evidence shows that the employee is unable to use these means of transportation, OWCP may authorize travel by taxi or special conveyance.

#### **Directed Medical Examinations**

Section 10.320 has been amended to add language allowing another person to be present at an OWCP-directed examination where there is rationalized medical evidence demonstrating that such a person is needed. Also note that another person may be allowed to be present as part of a reasonable accommodation under federal disability non-discrimination law.

Section 10.323 has been amended by expressly noting that examinations required by OWCP include any testing in connection with such an exam, e.g. a functional capacity evaluation. A new paragraph (b) was also added which details the process of how OWCP suspends compensation for obstructing a medical examination, as well as to explain how the employee can end that obstruction.

### **Subpart E--Compensation and Related Benefits**

Subpart E (§§10.400 through 10.441) is largely unchanged from the prior regulation. Of the changes made to this subpart, most are to clarify the prior regulation by codifying ECAB case law or to promote administrative efficiency.

A few additions have been made, including the addition of the skin as a schedule member and including language regarding electronic payments and their effect on overpayments.

### **Compensation for Disability and Impairment**

Section 10.401 has been amended to reflect the change in when the waiting period begins for Postal Service employees after the amendment to 5 U.S.C. 8117 as described earlier.

Section 10.403 has been amended to restore the factors used in determining wage-earning capacity as outlined in 5 U.S.C. 8115 (the nature of the injury, the degree of physical impairment, the usual employment, the age of the employee, the employee's qualifications for other employment and the availability of suitable employment) where actual earnings do not fairly and reasonably represent that capacity.

Section 10.404, which describes how compensation is paid for loss to schedule members under 5 U.S.C. 8107, has been revised to include the statutory schedule members as well as those that have been added by regulation. This section has also been amended to include the skin as a schedule member, for up to 205 weeks of compensation, for injuries sustained on or after September 11, 2001.

### **Compensation for Death**

Section 10.410 has been amended to clarify that survivor's benefits under 5 U.S.C. 8133 are separate and distinct from the death gratuity benefits under 5 U.S.C. 8102a.

Section 10.413 has been amended to codify in the regulations the requirement of 5 U.S.C. 8109 and ECAB case law, which states a claim for a schedule award must be filed while the claimant is still alive in order for the claim to be paid.

Section 10.415 has been amended to modernize the regulation to provide additional detail on handling the increasing number of governmental payments made by electronic fund transfer (EFT). The regulation now provides that if a beneficiary, or someone acting on his or her behalf, receives a check *or electronic payment* which includes payment of compensation for any period after the date when entitlement ended, he or she must promptly return such funds to OWCP.

Section 10.417 has been revised to streamline the process by which employees establish dependency based on student status and adult children who are incapable of self-support.

In this section, OWCP has reduced the reporting requirements in both of these instances to once each year, while placing an affirmative duty on the employee to report any change in the conditions to OWCP. Furthermore, this section was amended to add a new section allowing an employee to establish the permanency of an adult child's mental or physical disability.

### **Adjustments to Compensation**

Section 10.423 has been amended to delete the discussion that suggested that claims for compensation were subject to garnishment from claims from other Federal agencies.

Section 10.425 has been amended to clarify that leave donated to an employee through an employing agency's leave program is not leave that may be restored through the leave buy back process.

### **Overpayments**

10.430 has been amended to address the issue of when a claimant receives, or has knowledge of, an electronic payment. The regulation now provides that OWCP will use the normal business transaction definition of such receipt, where a payee is presumed to have knowledge of any payment once the payee has had the opportunity to receive a bank statement from the payee's financial institution.

Section 10.433, which pertains to when OWCP can waive recovery of an overpayment, was likewise amended to reflect that an employee is required to review such bank statements in order to ensure proper receipt of FECA benefits.

Section 10.440 was amended to include District Court and ECAB case law which allows OWCP to pursue collection of a debt while any such determination is pending before ECAB.

Section 10.441 was amended to describe the process used by OWCP to collect overpayment debts following the death of an employee. The regulation now provides that if no further benefits are payable with respect to the individual's death, OWCP may file a claim with the estate of the individual or seek repayment of the overpayment through other means, including referral of the debt to the Treasury Department.

## **Subpart F—Continuing Benefits**

Subpart F (§§10.500 through 10.541) is also largely unchanged. Most changes clarify the prior regulations by further describing the procedures and policies of OWCP and by including ECAB case law explaining those prior regulations.

### **Rules and Evidence**

Section 10.500 was restructured to more clearly provide information to claimants regarding their obligation to perform light duty when the evidence establishes that work is available within the employee's restrictions and that compensation for wage loss due to disability is available only for any periods during which an employee's work-related medical condition prevents him or her from earning the wages earned before the work-related injury. While this section does not provide any new information or communicate a change in interpretation of current law, the expectations have now been more clearly defined and examples have been provided in the regulation itself. Subsection (a) now outlines that an employee is not entitled to compensation for any wage loss claimed on a CA-7 to the extent that evidence contemporaneous with the period claimed on a CA-7 establishes that an employee had medical work restrictions in place; that light duty within those work restrictions was available; and that the employee was previously notified in writing that such duty was available. Similarly, an employee receiving continuing periodic payments for disability was not prevented from earning

the wages earned before the work-related injury if the evidence establishes that the employing agency had offered, in accordance with OWCP procedures, a temporary light duty assignment within the employee's work restrictions. This kind of determination, however, is separate and distinct from the kind of decision referenced in sub-section (c), which provides that a disabled employee who refuses to seek or accept suitable employment within the meaning of 5 U.S.C. 8106(c)(2) is not entitled to compensation.

Section 10.501 was amended to include a new subparagraph (2), which allows OWCP to require less medical documentation for continuing benefits where circumstances merit such reduced documentation, but the regulation maintains that this will ordinarily not be less than once every three years.

### **Return to Work – Employer's Responsibilities**

Section 10.509 was also modified by splitting that prior section into two sections, §§10.509 and 10.510. Section 10.509 now covers only situations involving the effect of downsizing of a light-duty position on compensation and states that, "In general, an employee will not be considered to have experienced a compensable recurrence of disability as defined in §10.5(x) merely because his or her employer has eliminated the employee's light-duty position in a reduction-in-force or some other form of downsizing."

Section 10.510 describes when a light duty job may be used as a basis for a loss of wage-earning capacity determination. It states that a light-duty position "may form the basis of a loss of wage-earning capacity determination if that light duty position is a classified position to which the injured employee has been formally reassigned. The position must conform to the established physical limitations of the injured employee; the employer must have a written position description outlining the duties and physical requirements; and the position must correlate to the type of appointment held by the injured employee at the time of injury. If these circumstances are present, a determination may be made that the position constitutes 'regular' Federal employment."

Section 10.511 is a new section that codifies longstanding ECAB case law which delineates the only circumstances under which a loss of wage-earning capacity determination may be modified (a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated, or the original determination was erroneous).

### **Return to Work--Employee's Responsibilities**

Section 10.517 has been modified to make clear that when an employee refuses to seek or accept suitable work, the resulting termination of compensation applies to any prior injuries in which compensation may be payable, as well as the claim under which compensation has ended.

Sections 10.518 and 10.519 have been modified to delete references to registered nurses under the vocational rehabilitation of employees, as ECAB ruled that the sanctions for failing to cooperate with vocational rehabilitation do not apply to nurse services.

Section 10.521 has been added to explain the process followed by OWCP when an employee that is involved in the vocational rehabilitation process or other return-to-work effort elects to receive benefits from the Office of Personnel Management instead of FECA benefits and is no longer participating in the vocational rehabilitation process. In such instances, OWCP may use the evidence of file to perform a loss of wage-earning capacity determination.

#### **Reports of Earnings From Employment and Self-Employment**

Section 10.525 has been amended to clarify that an employee must report all employment activities, including all outside employment, as such employment is material to a disability determination. This is so even where such earnings from concurrent dissimilar employment held at the time of injury do not reduce compensation payable but may still assist OWCP in assessing disability for work.

Section 10.526 has been amended to clarify that in reporting volunteer activities, the fact that the employee received no monetary compensation for those activities is not a basis for not reporting those activities to OWCP under ECAB case law.

#### **Reports of Dependents**

Section 10.537 was amended to reflect the change in reporting for non-minor children to once a year as described above in the discussion regarding §10.417.

#### **Reduction and Termination of Compensation**

Section 10.540 has been reorganized by splitting paragraph (a) into new paragraphs (a) and (b), to promote clarity and ease of use of the section. Paragraph (a) refers to providing the beneficiary with written notice of a proposed action and 30 days to submit relevant evidence or argument to support entitlement to continued payment of compensation. Paragraph (b) outlines the requirements to be included in such notice and stipulates that payment of compensation will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until 30 days have elapsed if no additional evidence or argument is submitted.

### **Subpart G--Appeals Process**

Subpart G (§§ 10.600 through 10.626) also continues largely unchanged; the changes that have been made were made to promote clarity and update the regulations to reflect changes in practice and technology that have taken place since the regulations were last updated.

#### **Reconsiderations and Reviews by the Director**

Section 10.606 has been modified to add language requiring that reconsideration requests be signed and dated so that OWCP can ascertain that the person (such as a representative) requesting reconsideration is authorized to do so at the time such request is made.

Section 10.607 has been modified by changing the date of the reconsideration

request for timeliness purposes from the date mailed to the date received by OWCP.

Section 10.609 has been modified to note that OWCP will not wait for comments from an employing agency regarding a request for reconsideration when comments from the agency are not germane to the issue being resolved on reconsideration. The regulation now specifically states that, "Where a reconsideration request pertains only to a medical issue (such as disability or a schedule award) not requiring comment from the employing agency, the employing agency will be notified that a request for reconsideration has been received, but OWCP is not required to wait 20 days for comment before reaching a determination."

### **Hearings**

Section 10.616 has been modified to accommodate alternative types of hearings, such as hearings by teleconference and videoconference.

Section 10.617 has been amended to cover a number of policies that were previously not contained in the regulation. First, this section has been amended to note how an employee may request accommodations from OWCP's Branch of Hearings and Review (BHR). This section has also been amended to note that hearings are generally limited to one hour, and to note that the transcript is the official record of the hearing. This section has also been modified to clarify the time limits for submitting comments following a hearing. Finally, a new paragraph (h) has been inserted as a reference to a statutory section that allows an OWCP hearing representative to certify any misconduct to a District Court for appropriate handling.

Section 10.618 has been amended to clarify that when an employee requests that a hearing be changed to a review of the written record, all evidence should be submitted with that request.

Section 10.619 has been amended to clarify that if a request for a subpoena has been made, the requestor must explain why that subpoena is necessary at the time the request is made. This section was further amended to allow subpoenas to be issued through a commercial carrier through a service equivalent to a certified mail, return receipt-requested letter.

Section 10.621 has been amended to clarify that it is in the discretion of the hearing representative whether the employing agency may be allowed to have more than one representative attend the hearing.

Section 10.622 has been amended in a number of ways. First, this section was amended to accommodate the alternative forms of hearings discussed above and to explain how these types of hearings are handled with a monthly docket. Sub-section (b) provides that OWCP will entertain any reasonable request for scheduling the oral hearing, including whether to participate by teleconference, videoconference or other electronic means, but such requests should be made at the time of the original application for hearing. Sub-sections (c) and (d) outline guidelines for rescheduling a hearing once one has been scheduled and OWCP has mailed appropriate written notice to the

claimant and representative. Sub-section (e) clarifies that any determination regarding scheduling (including format) is at the sole discretion of the hearing representative and is not reviewable. This section has also been amended to add new sub-section (f), which restores prior regulatory language addressing abandonment of hearings.

#### **Review by the Employees' Compensation Appeals Board (ECAB)**

Section 10.626 has been amended to cross reference ECAB's rules of procedure.

### **Subpart H--Special Provisions**

While a majority of the provisions in subpart H (§§10.700 through 10.741) remain unchanged, some extensive changes have been made to certain portions of this subpart. This subpart has been changed to reference that an attorney associated with a law firm may represent claimants and to explicitly state that OWCP will communicate with the law firm. The regulation clarifies OWCP policy that contingency fees are not allowed under any circumstances. The FECA subrogation sections have been expanded to codify current practice; to promote transparency and clarity where a third party is responsible for an injury or death; and to better explain how subsequent FECA subrogation claims are handled. Finally, the provision relating to coverage of Peace Corps volunteers has been amended to restore statutory language concerning such coverage.

#### **Representation**

Section 10.700 has been amended to clarify that where a claimant's representative is an attorney, OWCP may communicate with any attorney or employee in the attorney's law firm.

Section 10.702 has been amended to clearly state that contingency fees are not allowed when representing beneficiaries under the FECA. This explicit language addressing contingency fees was removed during the 1999 regulatory update; however, experience since that update has shown that the removal of this language caused some to believe that the ban on contingency fees had been removed as well, which was not the case.

Section 10.703 has been amended to make clear that OWCP can only approve representative's fees for services that have been performed before OWCP, and references that ECAB must approve fees for services performed in front of ECAB. This section has also been amended to clarify that contingency fees will not be approved for any reason, and that they are not subject to the "deemed approved" process where a fee may be approved if a claimant concurs with such a fee. If the fee is disputed, the regulations provide that OWCP will consider the customary local charge for a representative with similar qualifications in considering what constitutes a reasonable fee.

Section 10.704 highlights that a person who collects a fee without OWCP approval may be charged with a misdemeanor.

#### **Third Party Liability**

Section 10.705 has been amended to give the full address where information

on subrogation claims may be sent.

Section 10.707 has been amended to require that certain information be submitted in circumstances where the employee is not the only plaintiff in a suit.

The provisions in 10.711 have been moved to 10.712 and the provisions in 10.712 have been moved to 10.711. The new order reflects the process of calculating the refund and surplus in accordance with the statement of recovery Form CA-1108. Section 10.711 reflects the procedures that have been in place for a number of years and sets out in great detail the manner in which the amount of recovery of the employee is determined including situations where property loss is part of the recovery or where loss of consortium or wrongful death and survival actions have been asserted. Section 10.712 now clarifies that the crediting of a surplus is done against both wage-loss compensation and medical benefits, and provides detail regarding the steps to follow in calculating the refund and surplus. This section also provides additional examples of how these calculations are made, including cases where loss of consortium and wrongful death and survival actions have been asserted.

Section 10.714 has been amended to clarify that OWCP may seek reimbursement for all types of benefits paid to an employee when that employee has successfully sued a third party for that injury. This section was also amended to clarify how that employee may obtain a copy of the disbursements made by OWCP in his/her claim.

#### **Peace Corps Volunteers**

Section 10.730 has been amended to restore the statutory language applicable to coverage of claims involving Peace Corps volunteers. The statutory language is a recognition of the difficulties for such volunteers to establish that certain injuries or illness are related to their covered activities. The change in language allows OWCP to consider evidence that controverts coverage, while still allowing the volunteer to establish the claim, and clarifies that a temporary aggravation of a preexisting condition may be paid without the necessity of accepting all disability related to that condition.

### **Subpart I--Information for Medical Providers**

A number of changes have been made to subpart I. The majority of these changes have been made to address OWCP's electronic bill processing system and to comport this processing with that done in other compensation programs administered by OWCP. This subpart has also been revised to modify the process by which OWCP excludes medical providers by including the Department of Labor's Office of Inspector General (DOL OIG) in the process.

#### **Medical Records and Bills**

Section 10.800 has been amended to describe OWCP's provider enrollment process and automated bill processing and authorization system, which has been substantially revised since the last time the regulations were updated.

Section 10.801 has been amended to clarify how medical bills are currently processed. In addition to those changes, this section has been amended to codify that OWCP may require nursing homes to abide by a fee schedule for admissions made after the effective date of the regulations, which will standardize billing practices and promote cost containment. This section has also been amended to provide language making it clear that providers must adhere to accepted industry standards when billing, i.e. billing practices such as upcoding and unbundling are not in accord with industry standards and such attempts to circumvent the fee schedule through these practices is prohibited under the regulations.

Section 10.802 has been amended to clarify how an injured employee currently seeks reimbursement for out of pocket expenses.

### **Medical Fee Schedule**

Section 10.805 has been revised in order to give the Director of OWCP the express authority to determine a fee schedule for services provided by nursing homes.

Section 10.809 has been revised to clarify that the fee schedule regarding medicinal drugs applies whether the drugs are dispensed by a pharmacy or by a doctor in his/her office. This section has also been modified by providing OWCP the authority to require the use of a specific contract provider for medicinal drugs in the future. Finally, the authority to require the use of generic drugs has been moved to this section as new subparagraph (c).

Section 10.811 has been amended to make clear that OWCP will not correct procedure or diagnosis codes on submitted bills. Instead, those bills will be returned to the provider for correction, as the responsibility for proper submission lies with the provider.

### **Exclusion of Providers**

Section 10.815 has been amended by adding new subsections (i) and (j), which set out additional reasons for excluding providers. These new reasons are failure to update a change in provider status and having engaged in conduct found by OWCP to be misleading, deceptive or unfair.

Section 10.816 has been amended to add new subsection (c), which clarifies that a provider may be voluntarily excluded without the exclusion procedures being initiated.

Section 10.817 has been amended to provide that the DOL OIG is primarily responsible for investigating possible exclusions of providers, not OWCP.

Sections 10.818 through 10.821 have been revised to change the deciding official in exclusion matters from just the Regional Director to the Regional Director or any other official specified by the Director of the Division of Federal Employees' Compensation. These sections have also been modified to recognize the role of DOL OIG. Finally, these sections were modified to allow service of decisions through a commercial carrier service equivalent to certified mail, return receipt requested.

Sections 10.823 through 10.824 have been modified to change the manner in which the administrative law judge's recommended decision becomes final. These sections were changed to reflect that no recommended decision regarding exclusion will become final until the Director of OWCP issues the decision in final form.

Section 10.825 has been amended to reflect current practices of OWCP, as OWCP may use discretion in determining who should receive a notice of exclusion.

Section 10.826 has been modified to correct terminology and to clarify that the Director of OWCP can order reinstatement of excluded providers.

### **Subpart J--Death Gratuity**

Subpart J (§§ 10.900 through 10.916) is unchanged.

### **20 CFR Part 25**

Section 8137 provides the conditions and parameters for FECA coverage for non-citizen, non-resident employees of the United States, any territory, or Canada. Part 25 describes how benefits will be paid to such employees. Under the statute, the Director has authority to create a special schedule. In the interest of fairness, the Director has created a new more comprehensive special schedule for disability that will pay benefits on an ongoing basis for up to two years and will pay a lump sum thereafter for cases of permanent total disability. Payment for death benefits will also be paid in a lump sum to facilitate benefit delivery and to ease administrative burdens.

### **Subpart A--General Provisions**

Section 25.1 has been revised to reflect a change in policy in the payment of compensation under the FECA to employees of the United States who are neither citizens nor residents of the United States, any territory, or Canada, as well as any dependents of such employees. The new regulation modifies the benefit structure for foreign nationals by using the authority under section 8137 to create a special schedule of compensation for foreign nationals to provide a reduced percentage of FECA benefits.

Section 25.2(a) has been revised to provide that the special schedule set forth in subpart B would apply to any non-citizen, non-resident federal employee who is neither hired nor employed in the United States, Canada or in a possession or territory of the United States, with respect to any injury (or injury resulting in death) occurring subsequent to the effective date of the publication of the final rule in the federal register.

Section 25.2(b) has been revised to provide that the special schedule in subpart B shall apply to cases unless the injured non-citizen, non-resident employee receives compensation pursuant to a specific separate agreement between the United States and another government (or similar compensation from another sovereign government); or the employee receives compensation pursuant to the special

schedule under subpart C; or the employee otherwise establishes entitlement to compensation under local law pursuant to section 25.100(e) of this part.

Section 25.2(c) has been revised to provide that compensation in all cases of such non-citizen, non-resident employees paid and closed prior to 60 days after the publication of the final rule in the federal register are deemed paid in full under 5 U.S.C. 8137.

Section 25.2(d) has been revised to provide that the compensation received under the special schedule set forth in subpart B, or as otherwise specified in 25.2(b), is the exclusive measure of compensation in cases of injury (or death from injury) to non-citizen, non-resident employees of the United States.

Section 25.2(e) was revised to clarify the information in former section 25.2(e) that compensation for disability and death of non-citizen, non-resident employees outside the United States under this part shall in no event exceed that generally payable under the FECA.

Section 25.3 remains unchanged, providing that the Director has the authority to make lump-sum awards (in the manner prescribed by 5 U.S.C. 8135) to settle claims pursuant to section 8137 of the FECA.

Section 25.4 remains unchanged except for subsection (c), which is revised to read "Verification of the employment and casualty by Department of Defense personnel" instead of "military personnel" to reflect that the responsibility for providing the type of evidence necessary to make a claim under this section resides with the Department of Defense.

Section 25.5 has been renumbered but otherwise remains unchanged, providing that an employee who is a permanent resident of any United States possession, territory, commonwealth or trust territory will receive full FECA benefits.

### **Subpart B – The Special Schedule of Compensation**

Section 25.100 has been amended to provide that the definitions under this subpart are generally the same as those provided under the rest of the FECA statute and regulations.

25.101 has been modified to describe how compensation for temporary total and partial disability, and permanent total and permanent partial disability, are paid to non-citizen, non-resident employees. Provisions under the former section 25.101 for death benefits have been revised and currently appear in section 25.102.

Section 25.101(a) has been amended to provide for temporary total disability where the injured employee is disabled for less than two years. Under this provision, the employee receives 50 percent of the monthly pay during the period of such disability.

Section 25.101(b) has been amended to provide for temporary partial disability where the injured employee is unable to earn equivalent wages to those earned at the time of injury but is not totally disabled for work. Under this section, the injured employee receives a proportional amount of compensation for the period of

disability. The compensation amount is that portion of compensation for temporary total disability, as determined under paragraph (a) of this section, which is equal in percentage to the degree or percentage of physical impairment caused by the disability.

Section 25.101(c) has been amended to provide for permanent total disability where the injured employee will be disabled for greater than two years. This section provides that the injured employee will receive a lump-sum settlement, made by the manner prescribed under 5 U.S.C. 8135, based on compensation equaling 50 percent of the monthly pay.

Section 25.101(d) has been amended to provide for permanent partial disability where there is permanent impairment involving the loss, or loss of use, of a member or function of the body. This section describes how compensation is paid for loss to schedule members, and has been revised to be consistent with the time periods listed under 5 U.S.C. 8107 and the regulations listed in 20 C.F.R. 10.404. In addition to the revision of the time periods, this section has been amended to include the skin as a schedule member, for up to 205 weeks of compensation. This change is consistent with changes made under Part 10. The employee will be paid in a lump sum according to 5 U.S.C. 8135, at 50 percent of the monthly pay.

Section 25.101(e) has been amended to provide that if a beneficiary can show that the amount payable under the special schedule would be demonstrably less than the amount payable under the law of his home country, the Director has the discretion to pay an amount in excess of the special schedule of compensation under 5 U.S.C. 8137(a)(2)(A), not to exceed the amount payable under FECA. This section provides that to request such benefits, the beneficiary must submit the following information: translated copies of the applicable local statute, as well as any regulations, policies and procedures the beneficiary avers are applicable, and a translated copy of an opinion rendered by an attorney licensed in that jurisdiction, or an advisory opinion from a court or administrative tribunal, that explains the benefits payable to the beneficiary.

Section 25.102 has been amended to describe how compensation for death of a non-citizen, non-resident employee is paid.

Section 25.102(a) has been amended to provide for burial expenses not to exceed \$800.

Sections 25.102(b)-(i) remain similar in the distribution of death benefits (as delineated in former sections 25.101(a)-(i)), but have been limited to a total of 50 percent of monthly pay.

Section 25.102(j) has been added to provide that death benefits should be paid in a lump sum where practicable pursuant to 5 U.S.C. 8135.

Section 25.102(k) has been added to provide if a beneficiary can show that the amount payable under the special schedule would be demonstrably less than the amount payable under the law of his home country, the Director has the discretion to pay an amount in excess of the special schedule under 5 U.S.C. 8137(a)(2)(A), not to exceed the amount payable under FECA. This section provides that the

beneficiary must submit the same information as noted in section 25.101(e).

Section 25.102(l) has been added to inform claimants that a FECA death gratuity of \$65,000 may be payable for the death of a non-citizen, non-resident employee, should the death be a result of injury incurred in connection with service with an Armed Force in a contingency operation as set forth in subpart J of Part 10.

**Subpart C – Extension of the Special Schedule of Compensation**

Section 25.202 has been amended to adjust the maximum amount of compensation payable under that section for inflation, and to provide an automatic, yearly escalator to that amount.

Section 25.203 has been amended to apply the special schedule created by subpart B to non-citizen, non-resident employees in the Territory of Guam, without the modifications contained in the prior regulations.

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Director for  
Federal Employees' Compensation

Distribution: List No. 1 – FolioViews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, Staff Nurses and Fiscal)

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**FECA BULLETIN NO. 11– 07**

**Issue Date: August 10, 2011**

**Subject:** Skin Schedule Awards

**Background:** On August 13, 2010, the Office of Workers' Compensation Programs (OWCP) published in the *Federal Register* a proposal to amend the regulations governing the administration of the Federal Employees' Compensation Act (FECA). On June 28, 2011 the new Regulations were published, and they are effective as of **August 29, 2011**. 20 C.F.R. 10.404, which describes how compensation is paid for loss to schedule members under 5 U.S.C. 8107, now includes the skin as a schedule member, for up to 205 weeks of compensation, for injuries sustained on or after September 11, 2001.

Effective May 1, 2009, the Division of Federal Employee's Compensation (DFEC) began using the Sixth Edition of the American Medical Association's Guides to the

Evaluation of Permanent Impairment for schedule award calculations, and any new schedule award skin impairment ratings will be calculated in accordance with this edition of the Guides.

**Applicability:** All National Office staff and District Office claims personnel.

**References:** 5 U.S.C. 8107 (22); 20 CFR §10.404

**Purpose:** To inform the appropriate personnel of the new schedule member and provide an explanation of the specific criteria used to assess a skin condition in accordance with the Guides, as well as instructions for how to obtain the necessary information.

**Actions:**

## **I. Initial Acceptance of Skin Conditions**

Traumatic conditions associated with the skin usually stem from direct physical trauma or thermal injuries and may result in scars. Skin conditions claimed as a result of work-related exposures (occupational disease) should specifically note the effect on the worker's skin condition upon removal of the offending agent. As many skin conditions are temporarily aggravated by work exposure but revert to their baseline upon cessation of exposure, accurately determining work-related causation for skin conditions may require a second opinion examination if the claimant's physician cannot provide the necessary opinion on causal relationship and permanency. While acceptance of an aggravation, or temporary aggravation, should be considered, especially in occupational disease cases, a schedule award may not be paid on the basis of a temporary aggravation.

## **II. Types of Skin Conditions**

Repeated exposure to certain chemicals can result in an immunological change that makes the worker permanently hypersensitive to the chemical and precludes future work with that, or related, chemicals. The worker may be completely asymptomatic when not exposed to the chemical, but patch testing will define the sensitivity and its severity. Strict avoidance of further contact with the sensitizing substance is essential for sensitized workers.

1. Dermatitis. Dermatitis occurring as a result of skin exposure to physical or chemical agents is common. The association between a product at work and the resultant skin disorder is confirmed through patch testing of the suspected product or products. Blood testing for antibodies to a variety of environmental allergens is available, but many types of blood testing are not scientifically valid. Such tests, alone, are not a valid basis for determining sensitivity to an agent and should be confirmed by skin-patch testing. A medical opinion stating that an agent at work caused a skin condition should be supported by patch testing results or must explain why such testing is not warranted due to the risk of repeated exposure. Specific exemptions for patch testing include arsenic and beryllium.

2. Atopic Dermatitis. Atopic dermatitis is by definition a hereditary skin disease;

therefore, it cannot be caused by factors of employment. It may be referred to as eczema, but that term is too broad, applying to several different types of skin disease, and thus should not be used for the purposes of FECA. Atopic dermatitis is associated with other allergic manifestations such as hay fever and asthma. However, as with any pre-existing condition, it may be worsened by exposure to chemical or physical agents. The aggravation should be temporary, with removal of the stressing agent allowing reversion to the baseline status. Atopic dermatitis is a chronic disease often requiring lifelong therapy.

3. Contact Dermatitis. This is a very common skin disorder, second only to atopic dermatitis in frequency. It is easily diagnosed due to the fact that it typically presents as a pattern on the skin matching the surface contact with the offending chemical or physical agent. Contact dermatitis is due to an allergic reaction, differentiating it from abrasions and burns. Patch testing provides the definitive diagnosis and should be considered the only appropriate diagnostic test. Treatment is primarily through avoiding contact with the offending substance.

4. Latex Allergy. This is a type of sensitization, common in certain industries, which can have both skin and systemic symptoms, depending on the degree of sensitization. Patch testing is the primary means of confirming sensitization. Those with a history of severe systemic reactions should be tested by an allergy specialist trained to handle such systemic reactions. Antibody testing can be used as a screening test, but a negative test does not exclude latex allergy.

5. Skin Cancers. The most common risk factors for work-related skin cancers are ultraviolet exposure, arsenic, and coal tar products. The three most common skin cancers are basal cell carcinoma, squamous cell carcinoma, and malignant melanoma. A thorough assessment of the worker's environment through industrial hygiene surveys should be used to identify potential risks for exposure to skin carcinogens.

6. Burns and Scars. Serious burns often result in scars which can cause cosmetic or functional problems. Scars should be described by their size, location, shape, color and evidence of ulceration. Impairment can occur due to loss of perspiration and sensation, especially if the scar covers a large surface area. Some scars require long-term therapy to maintain pliability to prevent impairment of the underlying body part. Scars that limit use of an extremity will need to be evaluated separately for that extremity's functional loss. Disfigurement due to scarring is addressed in section VI below.

### **III. Principles of Assessment in the AMA Guides, Sixth Edition**

1. Chapter 8 in the AMA Guides outlines specific criteria to be considered when calculating permanent impairment of the skin.

2. In assessing skin impairment, the physician must evaluate the severity of the condition; the frequency, intensity, and complexity of the medical condition and treatment regimen; and the impact of the condition on the ability to perform Activities of Daily Living (ADLs). ADLs include bathing, dressing, eating, personal hygiene, etc.

3. Burden of Treatment Compliance (BOTC) must also be considered, as it can be significant for skin disorders. BOTC includes, but is not limited to, the following kinds of activities: soaking affected skin daily, applying topical medications on a regular basis, avoiding sun exposure, or attending phototherapy sessions on a routine basis.

#### **IV. Developing a Claim for a Schedule Award for the Skin**

1. Prior to development, confirm that the injury for which the schedule award is being claimed was sustained on or after September 11, 2001. The regulation provides for schedule awards for the skin only for injuries sustained on or after September 11, 2001. Any request for a skin schedule award for an injury prior to that date should be denied. For purposes of an occupational exposure, it must extend on or after September 11, 2001.

2. Upon receipt of a claim for a skin schedule award where the injury was sustained on or after September 11, 2001, the CE should send a development letter to the claimant outlining the information needed. The CE may instead send such a letter directly to the attending physician (AP), but the claimant should receive a copy so that he/she is aware of the required evidence and the timeframe for submission.

3. A medical evaluation for skin impairment should address all of the following specific areas, which are mentioned in the *Skin Schedule Award Development Letter* attached to this bulletin:

a) The diagnosis on which impairment is based and an opinion on whether the condition existed prior to the work-related exposure, and what, if any, impact the accepted work activity/exposure had on the condition. Impacts on a skin condition include a worsening of the signs or symptoms. Adverse impact includes an increased distribution of the skin condition, worsening of pre-existing lesions, or an increase in the therapy required to maintain control of the skin condition.

b) The variability in the skin condition over time. (How often the skin condition is present is noted as percentage of the time lesions are present.)

c) Documentation of the BOTC required to control the skin condition when removal from exposure has not resulted in resolution of the skin condition.

d) The impact on the worker's life activities. There are several questionnaires that are scientifically accepted as valid for measuring the impact of skin conditions on people's quality of life. These include the Dermatology Life Quality Index (DLQI), Dermatology Specific Quality of Life (DSQL), Skindex 29, Skindex 17, and the Dermatology Quality of life Scale (DQOLS).

e) A recommended percentage of impairment, with an explanation of that percentage based on the criteria/tables outlined in the AMA Guides, Sixth Edition. The impairment provided should relate to only the skin condition and not other underlying impairments associated with disfigurement or loss of function, since these should be addressed separately.

f) Whether MMI has been reached and, if so, the date of MMI.

4. After the case has been developed and the claimant has had an opportunity to submit the necessary evidence, the CE will review the file for the next appropriate action. If the AP provides a report of impairment, the case should be referred to the District Medical Advisor (DMA) for review. If the AP is unwilling or unable to provide such a report, and the medical evidence indicates that the claimant had an injury to the skin and may have a permanent impairment, the CE should refer the case for a second opinion examination.

5. If the claimant does not provide any evidence in response to the development within the response period, there is no evidence of impairment as outlined in this bulletin, and the case has only been accepted for an aggravation or temporary aggravation of a skin condition or a condition that would not typically result in a permanent impairment, the CE may deny the award. If in doubt, the CE should obtain an opinion from the DMA prior to such a denial.

6. When referring the case to the DMA, the CE should ask the DMA to verify the calculations of the AP or second opinion examiner and determine the percentage of permanent impairment based on the standards outlined in the AMA Guides. If the DMA determines that further information is necessary prior to providing a rating, he/she should specify the missing information so that it can be requested from the AP or second opinion examiner.

7. The DMA's determination of impairment must be thorough, especially when there is more than one evaluation of the impairment present. He/she must reference the physical findings, BOTC, etc.; show how he/she applied the criteria/tables in the Guides; and provide a clear explanation regarding the calculation. The DMA should also provide a reasoned opinion regarding the MMI date and explain any difference between his or her findings and the findings of the AP or second opinion examiner. This is necessary to determine whether weight can be assigned to the DMA or whether a conflict of medical opinion exists.

8. If the DMA **concurs** with the AP or second opinion impairment rating, the MMI date is established, and the DMA provided a rationalized opinion, the CE can proceed at that time to issue a schedule award decision based on the agreed-upon impairment rating.

9. If the DMA **does not concur** with the AP or second opinion impairment rating, the claimant has been provided with the opportunity to submit the necessary evidence, and the DMA provides a detailed and rationalized opinion in accordance with the AMA Guides, the CE should weigh the medical opinions and then either proceed with the DMA's rating or declare a conflict and proceed to a referee examination.

- If an opinion on the percentage of permanent impairment and a description of physical findings is on file, but the percentage estimate by the attending or second opinion physician is not based on the AMA Guides, an opinion by the DMA which gives a percentage based on reported findings and the AMA Guides may constitute the weight of the medical evidence. The CE must ensure, however, that the DMA properly considers all reported findings, gives rationale, and uses the AMA Guides, Sixth

Edition.

10. If a referee opinion is obtained, once the report is received the case should be referred back to a different DMA for review. In cases where a referee specialist is involved, the role of the DMA is to verify the referee's report for correct application of the AMA Guides, thereby confirming the percentage of permanent impairment. The DMA's role, however, is not to resolve the conflict in medical opinion, and he/she should not try to clarify or expand on the referee's medical opinion.

## V. Calculating an Award

1. The AMA Guides express the impairment of bodily organs, including the skin, in terms of the whole person; however, a schedule award under the FECA is based on the percentage of impairment of the particular organ. Therefore a conversion formula, as outlined in FECA Procedure Manual 3-0700-4(d), is used to calculate the organ-specific rating under the FECA.

2. According to the Guides, the maximum allowable whole-person impairment for the skin is 58%. The final impairment payable for the skin is determined by dividing the actual whole person impairment of the claimant by the maximum allowable (58%) and then converting that number to a final percentage.

3. Example: If a worker's impairment using the Guides is 30%, divide 30 by 58, which equals 0.52. Multiply by 100 to get a percentage of 52% for the organ system (skin).

## VI. Disfigurement

1. Scars are a form of disfigurement, and they may or may not impair function of the affected body part. If scarring impairs movement or function of a limb, then such impairment is addressed by an assessment of the limb's function, not the skin overlying the limb. Disfigurement also includes discoloration or a change in shape or structure of the skin. Impairment due to disfigurement or scars must note impact on the worker's life style, self-image or behaviors. Facial disfigurement is based upon alterations or permanent change to the underlying facial structures, not necessarily the skin. Ensure that cosmetic-based impairments are due solely to skin changes and have not been addressed and compensated already in another impairment rating.

2. The addition of skin as a schedule member does **not** replace the ability of OWCP to pay compensation for disfigurement in conjunction with § 10.404(e). Based on this authority, OWCP can pay additional compensation not to exceed \$3,500 for serious disfigurement of the face, head or neck which is likely to handicap a person in securing or maintaining employment.

3. Under 5 U.S.C. 8107(21), a disfigurement award may be paid concurrently with other schedule awards. Therefore, a skin schedule award may be payable based on the criteria described in this bulletin **in addition** to an award paid for serious disfigurement of the face, head or neck.

**Disposition:** This bulletin is to be retained until the FECA PM has been updated.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 1 – FolioViews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, Staff Nurses and Fiscal)

Attachment to FB 11- 07, **Skin Schedule Award Development Letter**

Dear Doctor:

We are seeking an opinion about your patient's work-related skin condition and any resulting permanent impairment. WORKER's case has been accepted for the following condition: ACCEPTED CONDITION.

Our program requires that all impairment determinations be calculated according to the Sixth Edition of the AMA's Guides to the Evaluation of Permanent Impairment. We would greatly appreciate a report from you, based on a recent examination, which provides the following information:

1. Whether the condition has reached maximum medical improvement and, if so, the date.
2. A detailed description of any permanent impairment that includes:
  - a) The diagnosis on which impairment is based and an opinion on whether the condition existed prior to the work-related exposure, and what, if any, impact the work activity or exposure had on the condition.
  - b) The variability in the skin condition over time.
  - c) Documentation of the Burden of Treatment required to control the skin condition when removal from exposure has not resulted in resolution of the skin condition.
  - d) The impact on the worker's life activities.
3. A final rating of the worker's impairment. Please include a discussion of the rationale for the calculation based on the applicable criteria and/or tables in the Sixth Edition of the AMA Guides.

This information is needed to properly make a decision regarding WORKER'S claim; therefore, please submit this information within thirty (30) days from the date of this letter. If you have any questions, please contact our office at the above address.

If you need additional information regarding FECA's skin schedule award policies, you may use the following link to access the policy guidance Bulletin issued in August 2011:

<http://www.dol.gov/owcp/dfec/procedure-manual.htm>

Thank you for your assistance. Please bill us your usual fee for a report of this type using Form HCFA-1500.

Sincerely,

## CLAIMS EXAMINER

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### **FECA BULLETIN NO. 11-08**

**Issue Date:** August 10, 2011

**Subject:** Exclusion of Providers

**Background:** On August 13, 2010, the Office of Workers' Compensation Programs (OWCP) published in the *Federal Register* a proposal to amend the regulations governing the administration of the Federal Employees' Compensation Act (FECA). On June 28, 2011 the new Regulations were published, and they are effective as of **August 29, 2011**. The regulations pertaining to the exclusion of providers were substantially revised.

**Applicability:** All National Office staff and District Office claims personnel; Department of Labor (DOL) Office of the Inspector General (OIG); Employing Agency (EA) personnel and OIG offices; and medical providers for FECA claimants.

**References:** 20 CFR §§ 10.815 – 10.826.

**Purpose:** To inform the appropriate personnel of the new regulations and provide instruction on the steps required to exclude a provider.

**Actions:**

1. A provider means a physician, hospital, or provider of medical services, appliances or supplies.
2. §10.815, which outlines the grounds for excluding a provider from payment under the FECA, was amended by adding two new sections (i) and (j). These new sections provide additional reasons for excluding providers. Under these regulations, a provider shall be excluded from payment under the FECA if the provider has:
  - (a) Been convicted under any criminal statute of fraudulent activities in connection with any Federal or State program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;
  - (b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any Federal or State program referred to in paragraph (a) of this section;
  - (c) Knowingly made, or caused to be made, any false statement or

misrepresentation of a material fact in connection with a determination of the right to reimbursement under the FECA, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a twelve-month period under this subpart containing charges which OWCP finds to be substantially in excess of such provider's customary charges, unless OWCP finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by the FECA and § 10.800;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards; or

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP.

(i) Failed to inform OWCP of any change in its provider status as required in section 10.800 of this title.

(j) Engaged in conduct related to care of an employee's FECA-covered injury that OWCP finds to be misleading, deceptive or unfair.

3. §10.816 was amended to add section (c), which clarifies that a provider may be voluntarily excluded without the exclusion procedures being initiated. This clarification is meant to address situations where providers agree to be excluded (for example, where a provider may be faced with criminal charges).

This section also includes automatic exclusions for any provider who has been convicted of a crime described in §10.815(a), or has been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in §10.815(b).

4. §10.817 was amended to provide that the DOL OIG is primarily responsible for investigating possible exclusions of medical providers. This duty was previously handled by OWCP; however, since OWCP has no investigatory arm and lacks resources to carry out this responsibility, this change in the exclusion process has been made in an effort to improve administrative efficiency of this process.

Upon receipt of information indicating that a provider has or may have engaged in

activities enumerated in §10.815(c) through (j), OWCP will forward that information to the DOL OIG for its consideration. If the information was provided directly to DOL OIG, DOL OIG will notify OWCP of its receipt and implement the appropriate action within its authority, unless such notification will or may compromise the identity of confidential sources, or compromise or prejudice an ongoing or potential criminal investigation. DOL OIG will conduct such action as it deems necessary, and, when appropriate, provide a written report to OWCP. OWCP will then determine whether to initiate procedures to exclude the provider from participation in the FECA program. If DOL OIG determines not to take any further action, it will promptly notify OWCP.

5. Any employing agency OIG wishing to submit an investigation pertaining to provider fraud should contact DOL OIG. Employing agency OIG offices should simultaneously notify OWCP; however, the report of investigation should be submitted to DOL OIG for review and appropriate action.

6. §10.817(c) refers to the type of report DOL OIG will prepare for OWCP consideration if there is reasonable cause to believe that violations of §10.815 have occurred. The report should be in the form of a single memorandum in narrative form with applicable attachments that can be easily referenced. The report should be sent to the DFEC Deputy Director (or his/her designee) and contain all of the following elements:

- i. A brief description and explanation of the subject provider or providers;
- ii. A concise statement of the DOL OIG's findings upon which exclusion may be based;
- iii. A summary of the events that make up the DOL OIG's findings;
- iv. A discussion of the documentation supporting the DOL OIG's findings;
- v. A discussion of any other information that may have bearing upon the exclusion process; and
- vi. The supporting documentary evidence, including any expert opinion rendered in the case.

7. §10.818 and §10.819 were revised to change the deciding official in exclusion matters from just the Regional Director to the Regional Director or any other official specified by the Director of the Division of Federal Employees' Compensation (DFEC). This change has been made in recognition of the fact that there may be instances (such as when more than one region is involved) where a Regional Director should not be the deciding official.

8. §10.818 discusses the notice that will be sent to the provider if OWCP determines there exists a reasonable basis to exclude the provider. If OWCP determines that such a basis exists, OWCP shall initiate the exclusion process by sending the provider a letter by certified mail and with return receipt requested (or other similar method), which contains the following elements:

- (a) A concise statement of the grounds upon which the exclusion shall be based;
- (b) A summary of the information, with supporting documentation, upon

which OWCP has relied in reaching an initial decision that the exclusion process should be initiated;

(c) An invitation to the provider to: (1) Resign voluntarily from eligibility for providing services under this part without admitting or denying the allegations presented in the letter; or (2) Request a decision on exclusion based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the deciding official, to request a formal hearing before an administrative law judge (ALJ);

(e) A notice that should the provider fail to answer the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The address to where the answer from the provider should be sent.

9. §10.819 discusses the requirements for the provider's response and indicates that it should be in writing and include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she can request that a determination be made upon the existing record and any additional information provided. The provider may also inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent.

Any response from the provider will be forwarded to DOL OIG by OWCP. If DOL OIG has any comments, they will be provided to OWCP within 30 days. OWCP will forward any comments from DOL OIG to the provider, who will then have 15 days to reply.

10. §10.819 also describes OWCP's decision making process. If the provider fails to answer the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and order exclusion of the provider. When a decision is made, the deciding official shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested (or other similar method). The decision shall advise the provider of his or her right to request, within 30 days of the date of an adverse decision, a formal hearing before an ALJ under the procedures set forth in §§10.820 through 10.823. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

11. §§10.820 through 10.822 provide guidance pertaining to requesting a hearing; how hearings are assigned and scheduled; and how subpoenas or advisory opinions are obtained during the hearing process. A request for a hearing should be sent to the deciding official. If the deciding official receives a timely request for hearing, the case is referred to the Chief ALJ of the Department of Labor, who shall assign it for an expedited hearing.

12. §10.823 and §10.824 were modified to change the manner in which the ALJ's recommended decision becomes final. Prior to this recent update, the decision became final if no objection was filed. Under the new Regulations, no recommended decision regarding exclusion will become final until the Director of OWCP issues the decision in final form.

13. At the conclusion of the hearing, the ALJ shall issue a recommended decision and cause it to be served on all parties to the proceeding, their representatives, and the Director of OWCP. Within 30 days from the date the recommended decision is issued, each party may state, in writing, whether the party objects to the recommended decision. This written statement should be filed with the Director of OWCP. For purposes of determining whether the written statement has been timely filed with the Director, the statement will be considered "filed" on the date that the provider mails it to the Director, as determined by postmark or the date that such written statement is actually received by the Director, whichever is earlier.

14. Written statements objecting to the recommended decision may be filed upon one or more of the following grounds: (1) A finding or conclusion of material fact is not supported by substantial evidence; (2) A necessary legal conclusion is erroneous; (3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director; (4) A substantial question of law, policy, or discretion is involved; or (5) A prejudicial error of procedure was committed.

If a written statement of objection is filed within the allotted period of time, the Director will review the objection and forward the written objection to DOL OIG for comment. DOL OIG will have 14 calendar days from that date to provide OWCP with any additional comments. Any additional comments from DOL OIG will be forwarded to the provider, and the provider will then have 14 calendar days from that date to reply to OWCP.

15. The Director of OWCP will consider the recommended decision, the written record, and any response or reply received and will then issue a written, final decision either upholding or reversing the exclusion. If no written statement of objection is filed within the allotted period of time, the Director of OWCP will issue a written, final decision accepting the ALJ's recommendation, and the decision of the Director of OWCP shall be final with respect to the provider's participation in the program and shall not be subject to further review by any court or agency.

16. §10.825 outlines the effects of exclusion. It provides that OWCP may give notice of the provider exclusion to the following parties: all OWCP district offices; all Federal employers; the CMS (Centers for Medicare and Medicaid Services); and the State or local authority responsible for licensing or certifying the excluded party.

17. Notwithstanding the exclusion of a provider, OWCP shall not refuse an employee reimbursement for any otherwise reimbursable medical treatment, service or supply if: (1) such treatment, service or supply was rendered in an emergency by an excluded physician; or (2) the employee could not reasonably have been expected to have known of such exclusion.

18. An employee who is notified that his or her attending physician has been excluded shall have a new right to select a qualified physician.

19. §10.826 was modified to clarify that the Director of OWCP can order reinstatement of excluded providers, as long as such decision is consistent with the goal to protect the FECA program against fraud and abuse. To satisfy this requirement, the provider must provide reasonable assurances that the basis for the exclusion will not be repeated.

20. If a provider was automatically excluded pursuant to §10.816, the provider will automatically be reinstated upon notice to OWCP that the conviction or exclusion which formed the basis of the automatic exclusion has been reversed or withdrawn. However, an automatic reinstatement shall not preclude OWCP from instituting exclusion proceedings based upon the underlying facts of the matter.

21. A provider excluded as a result of an order issued under these regulations may apply for reinstatement one year after the entry of the order of exclusion, unless the order expressly provides for a shorter period. An application for reinstatement should be addressed to the Director for Federal Employees' Compensation and shall contain a concise statement of the basis for the application, as well as supporting documents and affidavits, if applicable.

**Disposition:** This bulletin is to be retained until the FECA PM has been updated.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 1 – FolioViews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, Staff Nurses and Fiscal)

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## Federal Employee Compensation Act (FECA) Circulars

**FECA CIRCULAR 11 - 01**

February 2, 2011

Subject: Bill Pay - Revision in the Reimbursement Rates Payable for the Use of Privately Owned Automobiles Necessary to Secure Medical Examination and Treatment.

Background: Effective January 1, 2011, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobile increased to 51 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, a determination has been made to apply the applicable rate to disabled FECA beneficiaries traveling

to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

Reference: Chapter 5-0204, Principles of Bill Adjudication, Part 5, Benefit Payments, Federal (FECA) Procedure Manual and 5 USC 8103.

Action: The Central Bill Pay (CBP) facility has updated its system to reflect the new rates. Since there is no action required at the District Office level, the rates are being provided for informational purposes only.

The following is a list of the historical mileage rates used to reimburse claimant travel expense:

01/01/1995 - 06/06/1996	30.0 cents per mile
06/07/1996 - 09/07/1998	31.0 cents per mile
09/08/1998 - 03/31/1999	32.5 cents per mile
04/01/1999 - 01/13/2000	31.0 cents per mile
01/14/2000 - 01/21/2001	32.5 cents per mile
01/22/2001 - 01/20/2002	34.5 cents per mile
01/21/2002 - 12/31/2002	36.5 cents per mile
01/01/2003 - 12/31/2003	36.0 cents per mile
01/01/2004 - 02/03/2005	37.5 cents per mile
02/04/2005 - 08/31/2005	40.5 cents per mile
09/01/2005 - 12/31/2005	48.5 cents per mile
01/01/2006 - 01/31/2007	44.5 cents per mile
02/01/2007 - 03/18/2008	48.5 cents per mile
03/19/2008 - 07/31/2008	50.5 cents per mile
08/01/2008 - 12/31/2008	58.5 cents per mile
01/01/2009 - 12/31/2009	55.0 cents per mile
01/01/2010 - 12/31/2010	50.0 cents per mile
01/01/2011 - Current	51.0 cents per mile

Disposition: This Bulletin should be retained in Chapter 5-0204, Principles of Bill Adjudication, Federal (FECA) Procedure Manual.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 2 - Folioviews Groups A and D (Claims Examiners, All Supervisors, District Medical Advisors, Technical Assistants, Rehabilitation Specialists, and Fiscal Personnel).

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FECA CIRCULAR 11 - 02

February 2, 2011

SUBJECT: Dual Benefits - FERS Cost of Living Adjustments

For the second year in a row, there will not be a raise in the Social Security Administration (SSA) benefits for 2011. This is due to the fact that there was no increase in the Consumer Price Index

for Urban Wage Earners and Clerical Workers (CPI-W) from the third quarter of 2008 to the third quarter of 2010, as reported by the Bureau of Labor Statistics. The CPI-W percentage of increase sets the amount of the SSA COLA, so the lack of increase results in no increase to SSA benefits.

Since there is no increase to account for, there will be no change to the amounts currently being offset for Federal Employees' Retirement System (FERS) Dual Benefits deductions.

The historical SSA cost of living adjustments are as follows:

12/01/2010 - 11/30/2011	0.0%
12/01/2009 - 11/30/2010	0.0%
12/01/2008 - 11/30/2009	5.8%
12/01/2007 - 11/30/2008	2.3%
12/01/2006 - 11/30/2007	3.3%
12/01/2005 - 11/30/2006	4.1%
12/01/2004 - 11/30/2005	2.7%
12/01/2003 - 11/30/2004	2.1%
12/01/2002 - 11/30/2003	1.4%
12/01/2001 - 11/30/2002	2.6%
12/01/2000 - 11/30/2001	3.5%
12/01/1999 - 11/30/2000	2.4%
12/01/1998 - 11/30/1999	1.3%
12/01/1997 - 11/30/1998	2.1%
12/01/1996 - 11/30/1997	2.9%
12/01/1995 - 11/30/1996	2.6%
12/01/1994 - 11/30/1995	2.8%

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

Distribution: List No. 1 - FolioViews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, Staff Nurses and Fiscal)

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**FECA CIRCULAR 11 - 03**

March 3, 2011

SUBJECT: Current Interest Rates for Prompt Payment Bills and Debt Collection

The interest rate to be assessed for the prompt payment bills is 2.625 percent for the period of January 1, 2011 through December 31, 2011. This new rate has been updated in the Central Bill Payment system tables. The rate for assessing interest charges on debts due the government has not changed. The interest rate for assessing interest charges on debts due the government remains 1.0 percent for the period of January 1, 2011 through December 31, 2011. Ordinarily, the rate of interest charged on debts due the U.S. Government is only changed in January, and is effective for the entire year. However, the rate may be changed in July if there is a difference in the Current Value of Funds (CVF) interest rate of more than two percent. The rate will be reviewed on July 1, 2011 to determine if the Treasury has changed the rate. Attached to this

Circular is an updated listing of both the Prompt Payment and Debt Management interest rates from January 1, 1985 through the current date.

Periodically, a question is raised as to whether the Prompt Payment Act (PPA) applies to situations where a request for payment is submitted by medical providers seeking reimbursement for services provided to federal employees under the Federal Employees' Compensation Act (FECA). The answer is no, as the PPA applies only to federal procurement contracts. It does not extend to the government's financial obligations that are statutory or regulatory in nature. 5 C.F.R. §§ 1315.1(a) - 1315.2(g); *New York Guardian Mortgagee Corp. v. United States*, 916 F.2d 1558 (Fed. Cir. 1990) (declining to award interest to mortgage company seeking interest on delayed payments made under VA mortgage-guarantee program); see also *Boers v. United States*, 243 F.3d 561, 2000 WL 1475538 at \*3 (Fed. Cir. 2000) (unpublished) (declining to award interest on benefits under the Dairy Indemnity Payment Program administered by the Agriculture Department). The Prompt Payment Act does not apply to medical providers' invoices under FECA because the agency's obligation to pay arises not out of an enforceable procurement contract between medical providers and the agency, but rather out of a statutory obligation to injured federal employees. See 5 U.S.C. § 8103. The relationship between OWCP and treating medical providers under FECA is not contractual. The enrollment process does not result in any sort of agreement between the medical provider and OWCP; it merely informs medical providers of the procedures for seeking payment for services rendered to injured federal employees.

DOUGLAS C. FITZGERALD  
 Director for Federal Employees' Compensation

Attachments

Distribution No. 2--Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisors, Technical Assistants, Rehabilitation Specialists, Staff Nurses and Fiscal Personnel)

Attachment to FECA Circular NO. 11-03 - PROMPT PAYMENT INTEREST RATES

01/1/11 - 12/31/11	2 5/8 %	07/1/97 - 12/31/97	6 3/4 %
01/1/10 - 12/31/10	3 1/4 %	01/1/97 - 06/30/97	6 3/8 %
07/1/09 - 12/31/09	4 7/8 %	07/1/96 - 12/31/96	7. 0 %
01/1/09 - 06/30/09	5 5/8 %	01/1/96 - 06/30/96	5 7/8 %
07/1/08 - 12/31/08	5 1/8 %	07/1/95 - 12/31/95	6 3/8%
01/1/08 - 06/30/08	4 3/4 %	01/1/95 - 06/30/95	8 1/8 %
07/1/07 - 12/31/07	5 3/4 %	07/1/94 - 12/31/94	7. 0 %
01/1/07 - 06/30/07	5 1/4 %	01/1/94 - 06/30/94	5 1/2 %
07/1/06 - 12/31/06	5 3/4 %	07/1/93 - 12/31/93	5 5/8 %
01/1/06 - 06/30/06	5 1/8 %	01/1/93 - 06/30/93	6 1/2 %
07/1/05 - 12/31/05	4 1/2 %	07/1/92 - 12/31/92	7. 0 %
01/1/05 - 06/30/05	4 1/4 %	01/1/92 - 06/30/92	6 7/8 %
07/1/04 - 12/31/04	4 1/2 %	07/1/91 - 12/31/91	8 1/2 %
01/1/04 - 06/30/04	4. 0 %	01/1/91 - 06/30/91	8 3/8 %
07/1/03 - 12/31/03	3 1/8 %	07/1/90 - 12/31/90	9. 0 %
01/1/03 - 06/30/03	4 1/4 %	01/1/90 - 06/30/90	8 1/2 %
07/1/02 - 12/31/02	5 1/4 %	07/1/89 - 12/31/89	9 1/8 %
01/1/02 - 06/30/02	5 1/2 %	01/1/89 - 06/30/89	9 3/4 %
07/1/01 - 12/31/01	5 7/8 %	07/1/88 - 12/31/88	9 1/4 %

01/1/01 - 06/30/01	6 3/8 %	01/1/88 - 06/30/88	9 3/8 %
07/1/00 - 12/31/00	7 1/4 %	07/1/87 - 12/31/87	8 7/8 %
01/1/00 - 06/30/00	6 3/4 %	01/1/87 - 06/30/87	7 5/8 %
07/1/99 - 12/31/99	6 1/2 %	07/1/86 - 12/31/86	8 1/2 %
01/1/99 - 06/30/99	5.0 %	01/1/86 - 06/30/86	9 3/4 %
07/1/98 - 12/31/98	6.0 %	07/1/85 - 12/31/85	10 3/8 %
01/1/98 - 06/30/98	6 1/4 %	01/1/85 - 06/30/85	12 1/8 %

Prior to 01/01/85                      Not Applicable

Attachment to FECA Circular NO. 11-03 - DEBT MANAGEMENT INTEREST RATES

01/1/11 - 12/31/11	1%
01/1/10 - 12/31/10	1%
01/1/09 - 12/31/09	3%
07/1/08 - 12/31/08	3%
01/1/08 - 06/30/08	5%
01/1/07 - 12/31/07	4%
07/1/06 - 12/31/06	4%
01/1/06 - 06/30/06	2%
01/1/05 - 12/31/05	1%
01/1/04 - 12/31/04	1%
01/1/03 - 12/31/03	2%
07/1/02 - 12/31/02	3%
01/1/02 - 06/30/02	5%
01/1/01 - 12/31/01	6%
01/1/00 - 12/31/00	5%
01/1/99 - 12/31/99	5%
01/1/98 - 12/31/98	5%
01/1/97 - 12/31/97	5%
01/1/96 - 12/31/96	5%
07/1/95 - 12/31/95	5%
01/1/95 - 06/30/95	3%
01/1/94 - 12/31/94	3%
01/1/93 - 12/31/93	4%
01/1/92 - 12/31/92	6%
01/1/91 - 12/31/91	8%
01/1/90 - 12/31/90	9%
01/1/89 - 12/31/89	7%
01/1/88 - 12/31/88	6%
01/1/87 - 12/31/87	7%
01/1/86 - 12/31/86	8%
01/1/85 - 12/31/85	9%

Prior to 01/01/85

Not Applicable

## Federal Employee Compensation Act (FECA) Transmittals

**FECA TRANSMITTAL NO. 11-01**

October 8, 2010

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**EXPLANATION OF MATERIAL TRANSMITTED:**

Part 0 of the Procedure Manual has been updated in its entirety to reflect the current organization of DFEC, updated references to various directives, and current practices pertaining to dissemination of said directives.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
0	0-0100	1-6 Exhibit 1	0	0-0100	1-5
0	0-0200	1-5	0	0-0200	1-6

File this transmittal sheet behind the checklist in front of the Federal (FECA)

Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B and D (Claims Examiners, All Supervisors, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-02**

February 24, 2011

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**EXPLANATION OF MATERIAL TRANSMITTED:**

Chapter 2-0813 has been revised in its entirety. This chapter now provides an overview of the entire Vocational Rehabilitation (VR) process and is therefore now titled Vocational Rehabilitation Services.

Four sections from 2-0811 have been incorporated into this chapter: Referrals for Vocational Rehabilitation Services, Return to Work with Previous Employer, Plan Development, and Return to Work with New Employer. Other than removing these sections, no other changes have been made to 2-0811. The remaining paragraph in 2-0811 is Nurse Services, and since this chapter will be revised to focus solely on nurse case management, it is being renamed Nurse Case Management at this time.

The first 3 paragraphs of 2-0813 outline the purpose of VR services; the statutory, regulatory and Program requirements pertaining to VR; and entitlement to compensation during the VR process.

Paragraph 4 discusses restoration rights with the Federal government under section 8151 of the FECA.

Paragraph 5 outlines the criteria for referrals for VR services. This discussion includes referrals for immediate placement, as well as those for work hardening programs and those for concurrent and task based rehabilitation services in conjunction with Field Nurse services.

Paragraph 6 discusses the Placement with Previous Employer (PPE) phase of VR.

Paragraph 7 outlines what happens during the Plan Development phase of VR and specifically identifies that jobs selected for a plan must be medically and vocationally suitable, as well as reasonably available.

Paragraph 8 discusses the Training phase of VR and the types of training that are available.

Paragraph 9 focuses on the Placement with New Employer (PNE) phase of VR.

Paragraph 10 provides details regarding Assisted Reemployment, which is a subsidy that can be used during PNE to encourage employers to choose qualified rehabilitated workers whom they might otherwise not hire.

Paragraph 11 details the VR services that are provided once an injured worker has returned to work.

Paragraph 12 outlines the various services that can be offered under the umbrella of Medical

Rehabilitation, including Occupational Rehabilitation Plans.

Paragraph 13 provides information on the use of the Interrupt status during VR services.

Paragraph 14 focuses on effective communication among the Claims Examiner, Rehabilitation Specialist, Rehabilitation Counselor, and the injured worker, and the importance of such communication for a successful VR effort.

Paragraph 15 provides guidance to Claims Examiners for managing medical issues during VR.

Paragraph 16 specifically discusses the effects of substance abuse and methods for addressing this particular medical issue during VR.

Paragraph 17 outlines the effects of non-cooperation during the various stages of VR services and discusses the various sanction decisions that may be issued.

Paragraph 18 provides guidance for the appropriate actions to take if OPM benefits are elected during the various stages of VR.

Paragraph 19 concludes with a discussion of the possible outcomes of VR.

Finally, two new exhibits have been added. Exhibit 1 is titled Physical Demand Definitions and Exhibit 2 is titled Environmental Conditions Definitions. These exhibits outline the definitions DFEC has adopted from the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles. These definitions should be used when comparing the established work restrictions to the physical requirements of positions identified in the Dictionary of Occupational Titles.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

The following chapters are being updated in their entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC has discontinued the practice of inserting page numbers when an entire chapter is reissued.

Remove		Insert		
Part	Chapter Paragraphs	Part	Chapter	Paragraphs
2	2-0811 7, 8, 10 and 11 Exhibits 2-3			
2	2-0813 1-13 Exhibits 1-4	2	2-0813	1-19 Exhibits 1-2

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 - Folioviews Groups A, B, and D (Claims Examiners, All Supervisors,

District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-03**

March 17, 2011

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**EXPLANATION OF MATERIAL TRANSMITTED:**

Chapter 2-0900 has been updated in its entirety to include more detailed explanations in all paragraphs. Additions have been made, and obsolete information and/or references have been deleted. Additionally, previous paragraphs 6 and 7 of the chapter have been reversed so that the prior paragraph 7 (Elements Included in Pay Rate) is now paragraph 6, and prior paragraph 6 (Elements Excluded from Pay Rate) is now paragraph 7.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
2	2-0900	1-12 Exhibit 1	2	2-0900	1-12 Exhibit
1					

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-0800 and 2-0806 have been revised in their entirety. Chapter 2-0800 now provides an overview of the initial development of claims, and the chapter itself has been renamed Initial Development of Claims. Chapter 2-0806 now provides an overview of the acceptance of claims and has been renamed Initial Acceptances.

The procedures contained in the revised 2-0800 are a compilation of those outlined in the prior 2-0800, Development of Claims, and 2-0806, Occupational Illness. Much of the prior 2-0800 has been incorporated into this revised chapter, and most of the prior 2-0806 has been deleted and incorporated into the new 2-0800.

**PM Chapter 2-0800, INITIAL DEVELOPMENT OF CLAIMS**

Paragraph 1 outlines the purpose and scope of the chapter.

Paragraph 2 outlines the types of claims, traumatic and occupational, and discusses the difference between basic and extended occupational disease claims. This paragraph also includes a discussion of administratively reviewed claims.

Paragraph 3 outlines the forms used for all types of claims and the completion of those forms. The paragraph also discusses how to handle incomplete and incorrect forms.

Paragraph 4 outlines the responsibilities for the claimant, OWCP and the employing agency.

Paragraph 5 outlines the general development of a case and how to identify and request necessary information.

Paragraph 6 discusses the circumstances in which a case may be accepted without a medical report in the file.

Paragraphs 7 and 8 outline the development of factual and medical evidence, including the sources of both types of evidence, how to resolve factual discrepancies, and phrasing questions to obtain both factual and medical evidence.

Paragraph 9 discusses the extended medical development of certain cases when the nature of exposure is in question, the diagnosis is not clearly identified, or the relationship of the condition to the exposure is not obvious.

Paragraph 10 discusses obtaining evidence from employing agencies and the procedures for requesting the evidence.

Paragraph 11 outlines the procedures for withdrawing a claim prior to adjudication.

Paragraph 12 discusses group injuries where two or more employees are injured in the same incident.

Exhibit 1 (Nature of Injury Codes) has been moved from the prior PM Chapter 2-0806 into this chapter. Some updates have been made as well based on available codes. The prior exhibit in this chapter was deleted since a sample/shell letter for withdrawal of a claim is available in Correspondence Library.

### **PM CHAPTER 2-0806, INITIAL ACCEPTANCES**

Paragraph 1 outlines the purpose and scope of the chapter and notes that disallowances are discussed in FECA PM 2-1400.

Paragraph 2 discusses the procedures for accepting the claim if the five basic requirements are met.

Paragraph 3 outlines the CE's responsibility to verify the claimant's work status and begin Disability Management actions, if appropriate, upon case acceptance.

Paragraph 4 outlines the procedures for when an injured worker is claiming multiple medical conditions.

Paragraph 5 discusses the resolution of a medical condition at the time of case acceptance and includes sample language that can be utilized in the acceptance letter to the claimant.

Paragraph 6 outlines the procedures for closing a case at the time of case acceptance and includes sample language.

Paragraph 7 discusses the CE's responsibility in addressing employing agency challenges and controversions and includes sample language.

Paragraph 8 outlines the procedures for determining whether a pre-existing medical condition has been aggravated by an injury or job duties.

Paragraph 9 discusses claims filed due to risk of future exposure or prevention of future injury and the CE's responsibility when this type of claim is filed.

All exhibits that were previously contained in 2-0806 have been deleted and there were no new exhibits added. The majority of the exhibits were sample development letters that were not moved into the new chapter since sample/shell letters are available in Correspondence Library. The prior Nature of Injury Codes exhibit was updated and moved into PM Chapter 2-0800.

DOUGLAS C. FITZGERALD

Director for  
Federal Employees' Compensation

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The following chapters are being updated in their entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
2	2-0800	1-14 Exhibit 1	2	2-0800	1-12 Exhibit
1					
2	2-0806	1-8 Exhibits 1-21	2	2-0806	1-9

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-05**

June 14, 2011

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**EXPLANATION OF MATERIAL TRANSMITTED:**

Chapter 2-0811 has been revised in its entirety. This chapter now provides details of the case management process during the Nurse Intervention period.

Paragraph 1 outlines the purpose and scope of the chapter, and provides related references in Chapter 2-0600 (Disability Management) and Chapter 3-0201 (Staff Nurse Services) and 3-0202 (Contract Field Nurse Certification).

Paragraph 2 provides an overview of the Disability Management (DM) process and how nurse intervention is an integral part of the management of a claim during this

period.

Paragraph 3 briefly outlines the role of each type of nurse: Staff Nurse (SN), Continuation of Pay Nurse (CN) and Field Nurse (FN).

Paragraph 4 discusses the CN intervention period, including how and when cases are assigned to CNs, the timeframes for CN activity, and the expectations for the CN. This paragraph also outlines the Claims Examiner's (CE's) role in adjudicating claims and initiating further DM actions if the CN case is closed and the claimant has not returned to work in a full-time capacity.

Paragraph 5 discusses the role and responsibilities of the FN.

Paragraph 6 outlines the FN's role in assisting claimants in returning to work and assisting CEs in moving a case towards resolution and stresses that early referral for nurse intervention services is critical to ensuring successful disability management. This paragraph also discusses different situations in which a FN is needed.

Paragraph 7 outlines the requirements for the FN referral and specifies that the referral should be specific to the circumstances of the case and include the goals of the intervention, the issues which the FN should address with the physician, and any pending adjudicatory actions.

Paragraph 8 discusses what should be expected from the FN during the assignment period and available options for the CE should the claimant choose not to cooperate with the FN.

Paragraph 9 focuses on how critical regular and timely communication between the CE, SN, and FN are to a successful outcome.

Paragraph 10 outlines the updated timelines for nurse assignments. A significant change is the removal of the "Interrupt" status. Instead of using more rigid timelines, DFEC is instead moving to purposeful decision making specific to each case with increased use of extensions. If there is something specific the FN can do to further the return-to-work effort and maximize medical recovery, extensions can be approved by the CE and then the Supervisor for a period not to exceed 10 months (with some exceptions). As long as there is a clear indication that FN services would be useful for a specific purpose and that purpose/direction has been provided to the FN as clearly evidenced in the file, extensions may be granted. 30-day extensions to monitor a full-time return to work and 60-day extensions to monitor a light duty return to work are automatic. And for optimal case management results, collaboration between the CE and SN is strongly encouraged and should occur when extensions are to be granted or if there is any question regarding the appropriateness of FN closure.

Paragraph 11 details the criteria for Dual Track Intervention and explains the circumstances where it may be beneficial to assign a Rehabilitation Counselor (RC) to a case in conjunction with a FN. The dual track approach is warranted if the Employing Agency (EA) is trying to accommodate the claimant's work restrictions but is having difficulty formulating a position, but vocational testing, an ergonomic evaluation, or assistive technology may assist the EA with the formulation of a job

offer. Dual tracking may also be useful if the claimant has a medical condition which is likely to lead to permanent work restrictions, and there is no possibility that the EA would be able to accommodate those restrictions, in which case the claimant may benefit from a collaborative approach where the FN continues to assist with medical recovery while the RC begins early vocational assessment and planning.

Paragraph 12 outlines the CE's responsibility to medically manage each case, even during the Nurse Intervention period. While the FN will be actively involved in working with the claimant, the physician, and the EA, the ultimate responsibility of managing the direction of the case continues to rest with the CE. The CE can direct the FN to obtain specific information from the physician, but if this is not effective, the responsibility rests with the CE.

Paragraph 13 provides some ideas regarding best practices that can be used during the nurse intervention phase of Disability Management.

Chapter 2-0600 is also being updated based on revisions to the Nurse Case Management chapter so that both chapters contain consistent guidance.

Paragraph 3 has been updated to remove the reference to Telephonic Nurses, since DFEC is no longer making that distinction.

Paragraph 8 has been updated to remove the references to Telephonic Nurses and reflect the new timelines for FN services. Updates were also made to reflect the various dual tracking scenarios in which task-based rehabilitation assignments may be made in conjunction with FN services.

Paragraph 9 has been similarly updated to reference the various dual tracking scenarios.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC has discontinued the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraph	Part	Chapter	Paragraphs
2	2-0811	5	2	2-0811	1-13

Three paragraphs in the following chapter are being updated.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter Paragraphs	Paragraphs	Part	Chapter	
2 and 9	2-0600	3, 8 and 9	2	2-0600	3, 8

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-06**  
27, 2011

July

**EXPLANATION OF MATERIAL TRANSMITTED:**

Chapter 3-0500 has been revised in its entirety. Information previously contained within the chapter has been updated and duplicative portions of the chapter have been deleted.

Prior paragraph 2, Initial Examinations, has not been included in this chapter, since the information can be found in 3-0300. Likewise, prior paragraph 6, Exclusion of Medical Evidence, has not been included in this section, since the information is already contained in 2-0810. Also, the prior Exhibit 1, Form CA-19, has been removed since it is outdated and other referral methods are now used.

The focus of this chapter is now solely on OWCP directed second opinion (SECOP) and impartial medical evaluations (IME); therefore, the name of the chapter has been changed from Medical Examinations to OWCP Directed Medical Examinations. This chapter now provides detail of the steps involved in scheduling OWCP directed examinations and using the current Medical Management application in the Integrated Federal Employees' Compensation System (iFECS).

Paragraph 1 outlines the purpose and scope of the chapter and provides related references in Chapter 2-0810 (Developing and Evaluating Medical Evidence), Chapter 3-0300 (Authorizing Examination and Treatment), and Chapter 3-0600 (Requirements for Medical Reports).

Paragraph 2 provides the statutory authority for SECOP and IME examinations, pursuant to section 8123 of the FECA.

Paragraph 3 focuses on when and how to refer a case for a SECOP. It discusses how physicians are chosen, what information to include with the referral, how a claimant is notified once a SECOP is scheduled, requirements for any special accommodations (e.g. hearing impaired claimant), and the Claims Examiner's (CE) responsibility in obtaining the SECOP report timely and ensuring that it is complete and addresses the necessary issues.

Paragraph 4 discusses the referee examination process, including how and when cases are referred. This paragraph highlights the importance of using the rotational system, currently the Medical Management application in iFECS, in the selection of IME specialists. It discusses the CE's role in identifying the need for an IME, the selection process for the IME physician, what information should be provided to the IME physician and the claimant, and requirements for any special accommodations. It also discusses the CE's responsibility in obtaining the IME report timely and ensuring that it is complete and addresses the necessary issues.

Paragraph 5 focuses on the Medical Management application in iFECS, which replaced the previous Physician Directory System. It discusses the rotational scheduling feature and how a file should be documented with the appointment information. This paragraph also outlines the circumstances in which an appointment can be scheduled outside the usual rotational guidelines and the documentation that is required if that occurs.

Paragraph 6 provides a comprehensive guide to appropriate codes available to document the reasons for bypassing a physician in the rotational system.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC has discontinued the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
3	3-0500	1-7 Exhibit 1	3	3-0500	1-6

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-07**

**September 2, 2011**

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EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-0900 was updated in its entirety earlier this year. A few additional updates are being made at this time to provide more clarity with regard to effective pay rate dates.

Paragraph 5, Effective Date of Pay Rate, has been modified in two places. Section (a) now includes a specific reference to the determination of an effective pay rate date in an occupational disease case. Section (c) now specifically discusses effective pay rate dates for schedule award cases. As a result, the prior section (c) that discussed death cases has now been moved to section (d) with no changes. Exhibit 1, Determining Effective Pay Rate Date for Schedule Awards, has also been updated.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

Remove			Insert		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
2	2-0900	5 Exhibit 1	2	2-0900	5 Exhibit
1					

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

**FECA TRANSMITTAL NO. 11-08**

**September 21, 2011**

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EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-0500 has been revised and updated to include new language, a change in the structure, and references to the two types of conferences – formal and informal. The chapter itself focuses on formal conferences though, as informal conferences during the Disability Management (DM) process are discussed in detail in PM Chapter 2-600-12.

Paragraph 1 provides an overview of the chapter.

Paragraph 2 outlines that both the Senior Claims Examiners (SrCE) and the GS-12 Claims Examiner (GS-12 CE) are responsible for conducting conferences, but also notes that non-journey level CEs may also participate in some types of conferences.

Paragraph 3 discusses the two specific types of conferences (formal and informal) and some of the distinctions between the two.

Paragraph 4 discusses the different types of cases suitable for formal conferences.

Paragraph 5 outlines the necessary steps the SrCE/GS-12 CE must take in preparing for a conference call.

Paragraph 6 discusses the necessary elements of a conference.

Paragraph 7 discusses actions required by the SrCE/GS-12 CE during the conference discussion.

Paragraph 8 outlines the essential elements of a Memorandum of Conference.

Paragraph 9 discusses when comments are required and when comments are not required after a conference is conducted.

DOUGLAS C. FITZGERALD  
Director for  
Federal Employees' Compensation

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The following chapter is being updated in its entirety. Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC has discontinued the practice of inserting page numbers when an entire chapter is reissued.

<u>Remove</u>			<u>Insert</u>		
Part	Chapter	Paragraph	Part	Chapter	Paragraphs
2	2-0500	1-9	2	2-0500	1-9

File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

Distribution: List No. 2 – Folioviews Groups A, B, and D (Claims Examiners, All Supervisors, District Medical Advisers, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

## **Office of Workers' Compensation (OWCP) Bulletins**